

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**17575**

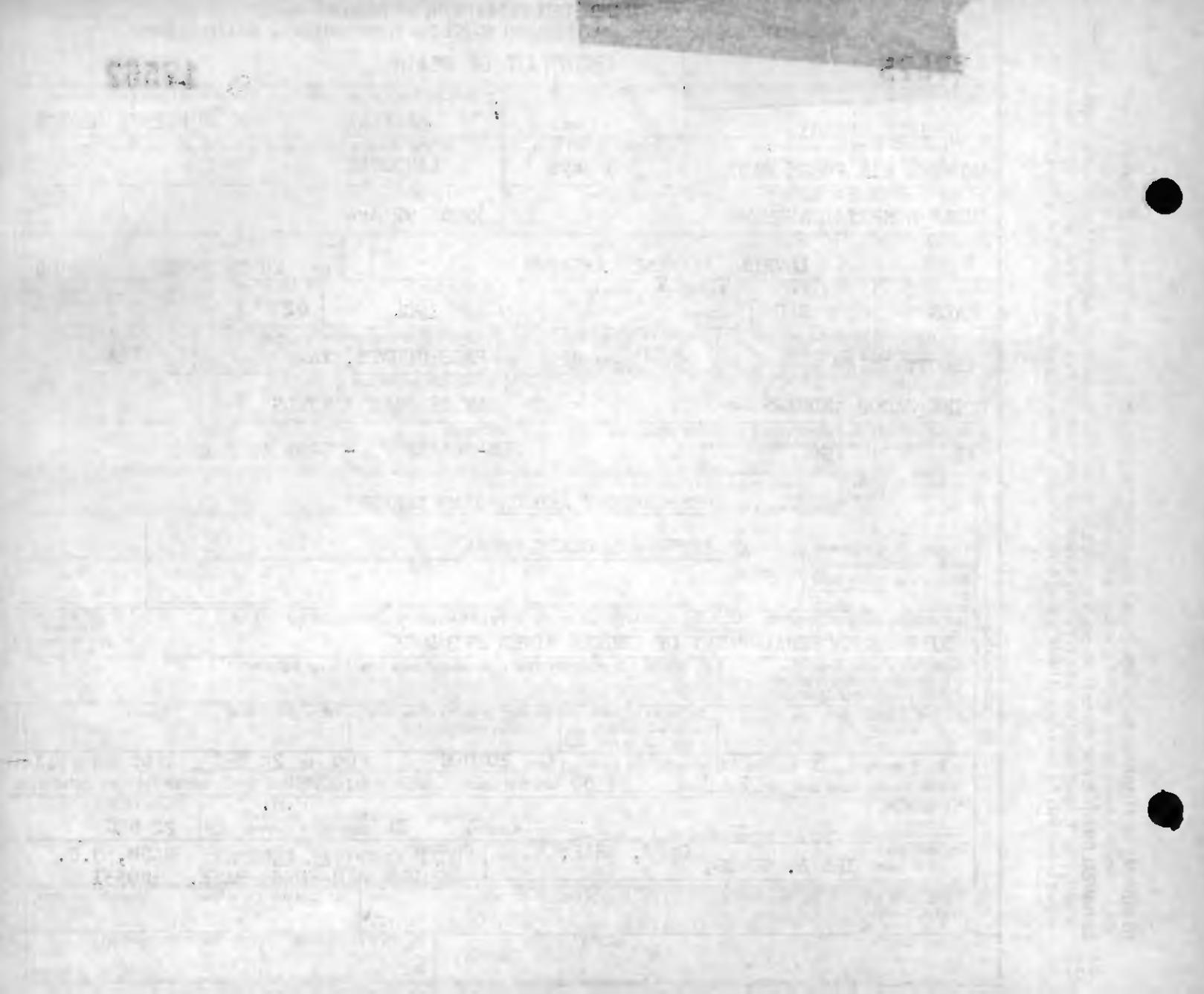
**CERTIFICATE OF DEATH**

**17562**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>			b. COUNTY <b>PRINCE GEORGE</b>		
c. LENGTH OF STAY IN lb <b>8 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANDOVER</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>			d. STREET ADDRESS <b>3906 92 Ave</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LOVELL EARNEST ANDREWS</b>			4. DATE OF DEATH <b>28 DECEMBER</b>	Month <b>1966</b>	Doy Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>9 DEC 1904</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTTRICIAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>	11. BIRTHPLACE (County & State, or foreign country) <b>PAGE COUNTY, VA</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>IRA JACOB ANDREWS</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE MARY SAMUELS</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>SON-CLARENCE * SAME AS # 2</b>	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY AND CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { (b) <b>ACUTE PULMONARY EDEMA</b> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIFFUSE ENCEPHALOPATHY OF UNDETERMINED ETIOLOGY</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (A) (this hospital) attended the deceased from <b>20 DEC 1966</b> to <b>28 DEC 1966</b> , that (I) (X) last saw the deceased alive on <b>28 DEC 1966</b> , and that death occurred at <b>11:10PM</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Dr. A. Gould</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>28 DEC</b>		
22c. PHYSICIAN'S NAME (Type) <b>IRA A. GOULD, CAPT, USAF, MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS ANDREWS AIR FORCE BASE, 20331</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-31-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>DELLINGER GRAVE YARD</b>	23d. LOCATION (City or Town) (County) (State) <b>SPRASBURG VA</b>	
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM</b>		ADDRESS <b>4308 SUITLAND RD</b>	25a. REC'D BY REGISTRAR <b>DATE: 1-3-1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17576

## CERTIFICATE OF DEATH

17568

Date # 14 - Info. from D.C. 12/16/66-MB

## 1. PLACE OF DEATH

## 2. COUNTY

PRINCE GEORGES

MARYLAND

## 3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ANDREWS AIR FORCE BASE

## c. LENGTH OF STAY IN 16

3 DAYS

## d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

USAF HOSPITAL ANDREWS

3. NAME OF  
DECEASED  
(Type or print)First  
JULIEMiddle  
ANNLast  
ATKINSON

## 5. SEX

FEMALE

## 6. COLOR OR RACE

CAU

## 7. MARRIED

## NEVER MARRIED

## 8. DATE OF BIRTH

1 DECEMBER 1966

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

N/A

## 10b. KIND OF BUSINESS OR INDUSTRY

N/A

## 11. BIRTHPLACE (County &amp; State, or foreign country)

PRINCE GEORGE'S, MARYLAND

## 12. CITIZEN OF WHAT COUNTRY?

U.S.

## 13. FATHER'S NAME

EUGENE FRANKLIN ATKINSON

## 14. MOTHER'S MAIDEN NAME

JULIE ANN ATKINSON Shirley Joan Jordan

Address

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (By giving name and date of service)

NO

N/A

## 16. SOCIAL SECURITY NO.

N/A

## 17. INFORMANT

FATHER SAME AS # 2

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

760.5

DUE TO  
(b)

Respiratory Arrest

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.DUE TO  
(c)Premature Lung & Intraventricular  
HemorrhageINTERVAL BETWEEN  
ONSET AND DEATH

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?YES NO 20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19 p.m.20d. INJURY OCCURRED  
While at work  Not While at work 

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

27. I certify that  (this hospital) attended the deceased from 1 DEC 1966 to 3 DEC 1966 that  (we) last saw the deceased alive on 3 Dec 1966 and that death occurred at 11 P.M. from the causes and on the date stated above.22b. DATE  
SIGNED

## 22a. SIGNATURE

Paul H. Perlstein

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22c. PHYSICIAN'S  
NAME (Type)PAUL H. PERLSTEIN, CAPT, USAF, MC  
M.D.

WASH, D.C. 20331

USAF HOSPITAL ANDREWS, ANDREWS AFB

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

## 23b. DATE THEREOF

8 DEC 66

## 23c. NAME OF CEMETERY OR CREMATORIUM

D.C. MORGUE CREMATION

## 23d. LOCATION (City, town or county)

WASHINGTON, D.C.

## (State)

## 24. FUNERAL DIRECTOR'S SIGNATURE

Carl J. Aufrecht

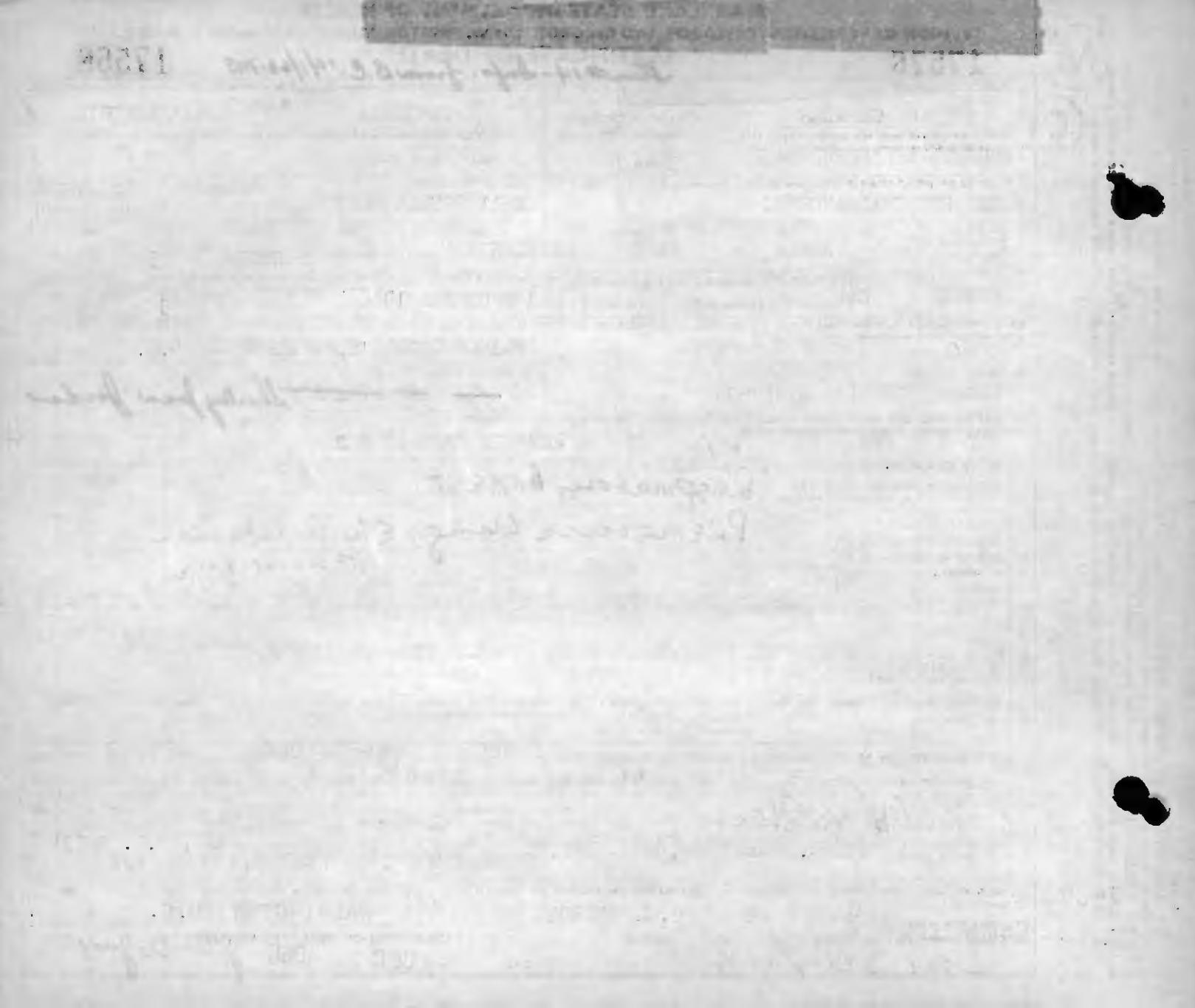
## ADDRESS

## 25a. REC'D BY REGISTRAR

DATE DEC 7 1966

## 25b. REGISTRAR'S SIGNATURE

Charles Judge



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17569

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGE GENERAL</b>		SEAT PLEASANT 16-1	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>G.</b>	Last <b>AUGUSTINE</b>
4. DATE OF DEATH	Month <b>DECEMBER</b>	Day <b>11</b>	Year <b>19 66</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 16, 1886</b>
9. AGE (In years last birthday) <b>80 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Service</b>	11. BIRTHPLACE (County & State, or foreign country) <b>HUNGRY</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>barber</b>	14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b> JULIA AUGUSTINE 6829 ROOSEVELT AVENUE Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>52 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/9/1959</b> to <b>12/11/1966</b> , that (I) (we) last saw the deceased alive on <b>12/10/1966</b> , and that death occurred at <b>954 M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>12/11/66</b>	
22a. SIGNATURE <b>E.E. Mosser, M.D.</b>		22b. DATE SIGNED <b>12/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>E.E. Mosser, M.D.</b>		22d. ADDRESS <b>4410 24th ave, Hyattsville</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>DEC. 13, 1966</b> CEDAR HILL CEMETERY	
24. FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b>		ADDRESS <b>4308 SUITLAND ROAD, SUITLAND MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>DATE DEC 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10081

10081



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

M

17578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17578

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Cheverly	c. LENGTH OF STAY IN lb  DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Hillside	d. STREET ADDRESS  4945 Marlboro Pike
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  Jackie	First  Sue	Last  Balderson	4. DATE OF DEATH 12 24 19 66
S. SEX  Female	6. COLOR OR RACE  White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 July 1947
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY  Finance	9. AGE (In years lost birthday) 19 yrs.
13. FATHER'S NAME  Herman Balderson		11. BIRTHPLACE (State or foreign country) Washington D. C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT Anna E. Blaine		Address Anna E. Blaine 1527 62nd Pl. Spaulding Hgts.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). storing the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  Shot self in chest with a .22 cal. revolver	
20c. TIME OF INJURY Month, Day, Year Hour o.m. am p.m. 12-23- 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) same as #2
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	22. DATE SIGNED 12-26-66
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/28/66	23c. NAME OF CEMETERY OR CREMATORIAL Epiphany Church Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24. FUNERAL DIRECTOR WILHELM FUNERAL HOME ADDRESS 4308 SUITLAND ROAD, SUITLAND MARYLAND		25a. REC'D. BY REGISTRAR DEC 29 1966 DATE	25b. REGISTRAR'S SIGNATURE Charles Judge

MC221

6775

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17579

## CERTIFICATE OF DEATH

17571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb. <b>27 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Raphael S Barton</b>			First	Middle	Last
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 - 14 - 1903</b>	9. AGE (In years last birthday) <b>62 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yardmaster</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		
13. FATHER'S NAME <b>Charles L Barton</b>			14. MOTHER'S MAIDEN NAME <b>Myrtle M Slayman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>718 14 9734</b>		
17. INFORMANT <b>Katheryn A Barton</b>			Address <b>College Park, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Blowout of gastroduodenostomy</b> (b) <b>Severe coronary arteriosclerotic Heart Disease</b> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Riverdale, Md.</b>	(County) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>11 - 7, 1966</b> , to <b>12 - 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>12 - 3, 1966</b> , and that death occurred at <b>3, 25 AM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>William B. Hagan M.D.</b>					
22b. DATE SIGNED <b>12-4-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>William B Hagan</b>			22d. ADDRESS <b>Riverdale, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) <b>Colmar Manor</b>	(County) <b>Pro Geo</b>
(State) <b>Md.</b>					
24. FUNERAL DIRECTOR <b>F Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>DEC 6</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

15291

90371

between 1960-8

united

between 1960-8

and 1970-8

1960-8

Vietnam

between 1960-8

between 1960-8 and 1970-8

1960-8

total

1960-8 + 1970-8

total

1960-8

between 1960-8 and 1970-8

between 1960-8

and 1970-8

between 1960-8 and 1970-8

total

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17580

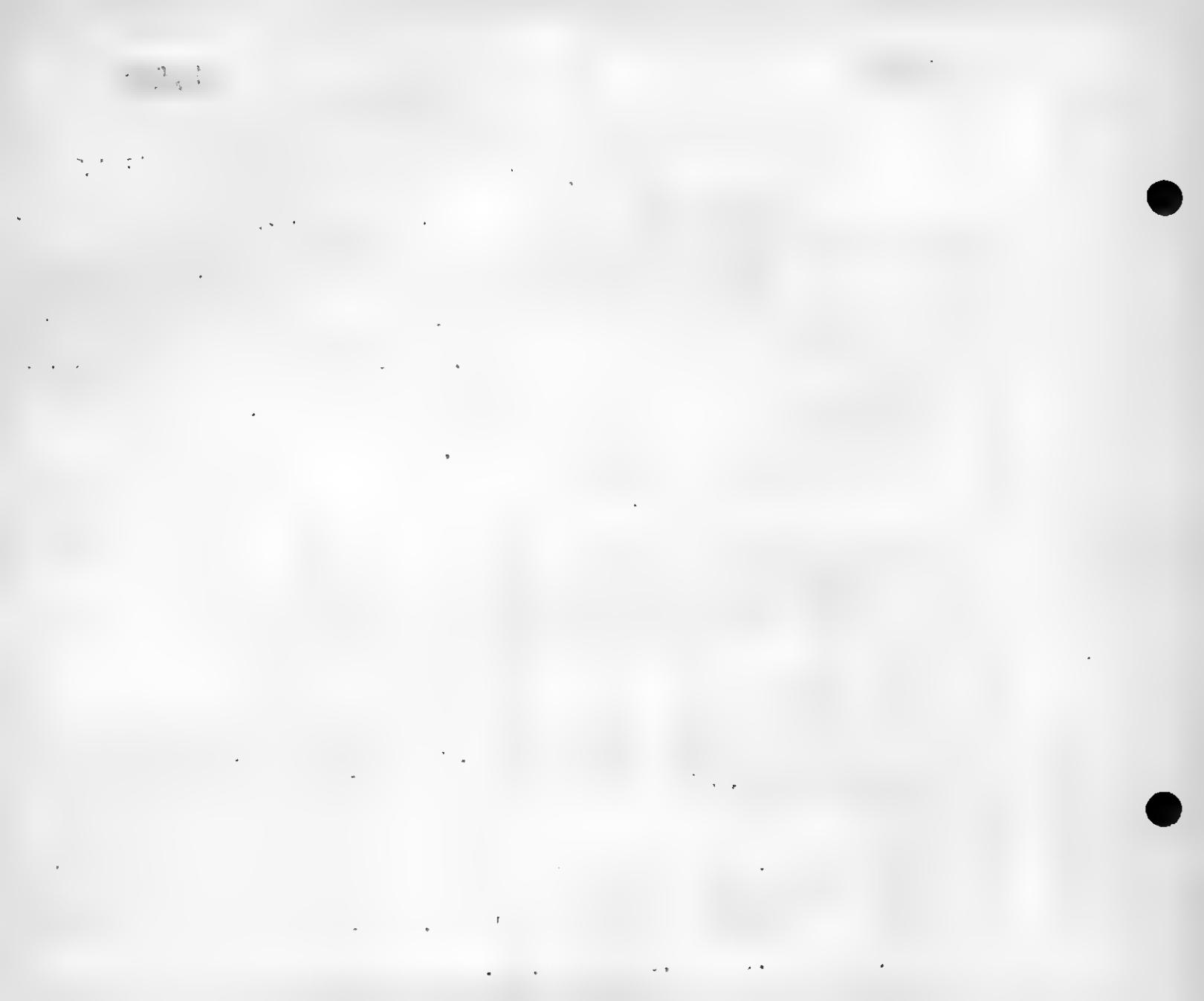
## CERTIFICATE OF DEATH

17572

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN TB 1 day 11 hrs, 15 min.	c. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6221 64th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16.1	
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	4. DATE OF DEATH Dec., 7 1966 Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> KK WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Dec., 1966 9. AGE (in years lost birthday) yes 1 months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert James Becker		14. MOTHER'S MAIDEN NAME Sandra Louise Burgess	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mother		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bilateral Atelectasis</i> <i>160.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Prematurity (1200 gms)</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1966 to Dec. 7, 1966, that (I) (we) last saw the deceased alive on Dec. 7, 1966, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE <i>J. J. H. C. M.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/7/66</i>
22c. PHYSICIAN'S NAME (Type) Bertha E. Van Gelderen, M.D.		22d. ADDRESS =3001 Cheverly Ave., Cheverly, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 12/17/66	23c. NAME OF CEMETERY OR CREMATORIAL Prince George's Gen. Hosp.
23d. LOCATION (City or Town) Cheverly		(County) PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md.		ADDRESS	25a. REC'D BY REGISTRAR DEC 21 1966
			25b. REGISTRAR'S SIGNATURE



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17581

## CERTIFICATE OF DEATH

17573

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in an event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>15 hrs</b>	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3407 Taylor Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>First: Milton Middle: Bell Lost: Bell - Milton</b>	4. DATE OF DEATH Month <b>Dec., 12</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Oct., 1901</b>
10a. JOBL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consulting Att.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pittsburgh, Penna.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank Buschek</b>	14. MOTHER'S MAIDEN NAME <b>Lillian Slaby</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO <b>217-44-2427</b>	17. INFORMANT <b>Mrs. Frances N. Bell (above address)</b>	Address <b>(Wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary emboli (Rt lung) &amp; edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>200.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO (b) <b>Coronary thrombosis (Rt coronary)</b> DUE TO (c) <b>Generalized carcinomatosis (lymphosarcoma)</b>		1 day <b>Several months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/14/66</b> to <b>12/12</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>12/12</b> , 19 <b>66</b> , and that death occurred at <b>30AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>John L. Bell</i>		22b. DATE SIGNED <b>12/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John L. Bell</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/14/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>	25a. ADDRESS <b>117 Rainier</b>	25b. REC'D BY REGISTRAR <b>Maryland</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 20 M 1/66	DATE <b>DEC 16 1966</b>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17582

CERTIFICATE OF DEATH

17574

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

W. HYATTSVILLE

c. LENGTH OF STAY IN lb

28 mos.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

HYATTSVILLE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

M.D.

b. COUNTY

MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SILVER SPRING 153

d. STREET ADDRESS

10317 NAGLEE RD.

e. IS RESIDENCE ON A FARM?

YES  NO

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month  
12 17

Year  
1966

5. SEX

F

6. COLOR OR RACE

WH.

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGF (In Years  
a. rthday) IF UNDER 1 YEAR IF UNDER 24 HRS.  
b. Months Days Hours Min.

1 - 11 - 1873 93 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED GOVT. U.S. GOVT INDUSTRY

11. BIRTHPLACE (County, State, Country)

WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DANIEL SPAULDING

14. MOTHER'S MAIDEN NAME

CECILIA DOWNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

579-12-7354A

17. INFORMANT

BARTHOLMEY

HELEN HUGHES

Address

10317 NAGLEE RD.

INTERVAL BETWEEN  
ONSET AND DEATH  
3 MO.

18. CAUSE OF DEATH [Enter only one cause per line]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

175.0

DUE TO

Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

CARCINOMA OF RIGHT OVARY

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)  
(County)  
(State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1966, to Dec. 17, 1966, that (I) was last  
saw the deceased alive on Dec. 15, 1966, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Thomas F. Collins

22b. DATE SIGNED

12-17-66

22c. PHYSICIAN'S  
NAME (Type)

THOMAS F. COLLINS

22d. ADDRESS

322 H ST NE

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

12-20-66

23c. NAME OF CEMETERY OR CREMATORIUM

CONGRESSIONAL C.I.M.

23d. LOCATION (City, town or county) (State)

WASHINGTON D. C.

24. FUNERAL DIRECTOR

Francis J. Collins

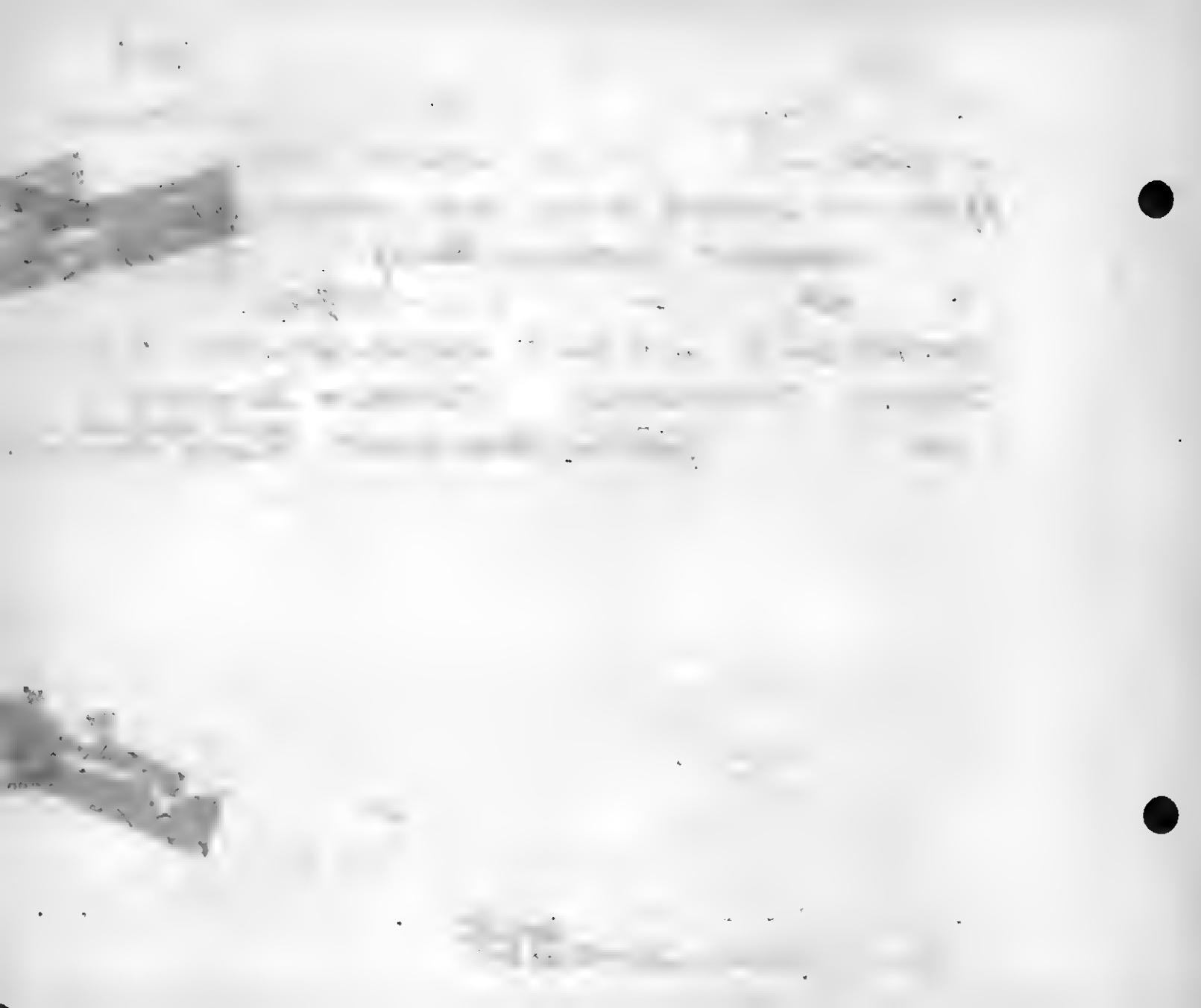
ADDRESS

3824-14th St NW

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE DEC 22 1966



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for all the burial-transit permit. Then please file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												17575					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)								
Prince George			Cheverly			MARYLAND			a. STATE Maryland			b. COUNTY Prince Geo.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Columbia Pk			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Prince George's General Hospital						1610 Columbia Ave											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year						
FRANK			J.	BOGAN		Dec 20, 1966			57	12	23	1966					
5. SEX			6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH			9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
M			W	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			57 yrs.	Months	Days	Hours	Min.			
Mechanic			automobile			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT					
Warrick C Bogan			Mathis F. Shelton			No			230 16 1694			Margaret M Bogan Columbia Park Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			19. INTERVAL BETWEEN ONSET AND DEATH			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Coronary Thrombosis, Acute			1 min					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO			DUE TO			Hypertensive Arteriosclerotic Cardiovascular Disease								
(b)			(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Diabetes Mellitus											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19																	
21. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on			10/21/1966, to 12/23/1966, that (1) (we) last			22a. SIGNATURE			22b. DATE SIGNED								
12/6/1966			from the causes and on the date stated above.			William D. Rosson, M.D.			12/23/66								
22c. PHYSICIAN'S NAME (Type)			ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>								
William D. Rosson, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CINERATORIUM			23d. LOCATION (City, town or county)			(State)					
Burial			Dec 27, 1966			Cleek Cemetery			Hot Springs, Virginia								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
F. Gasch's Sons			Hyattsville, Md.			DEC 27 1966			Charles Judge								
VR A15 (4) 20M 1/65																	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17584

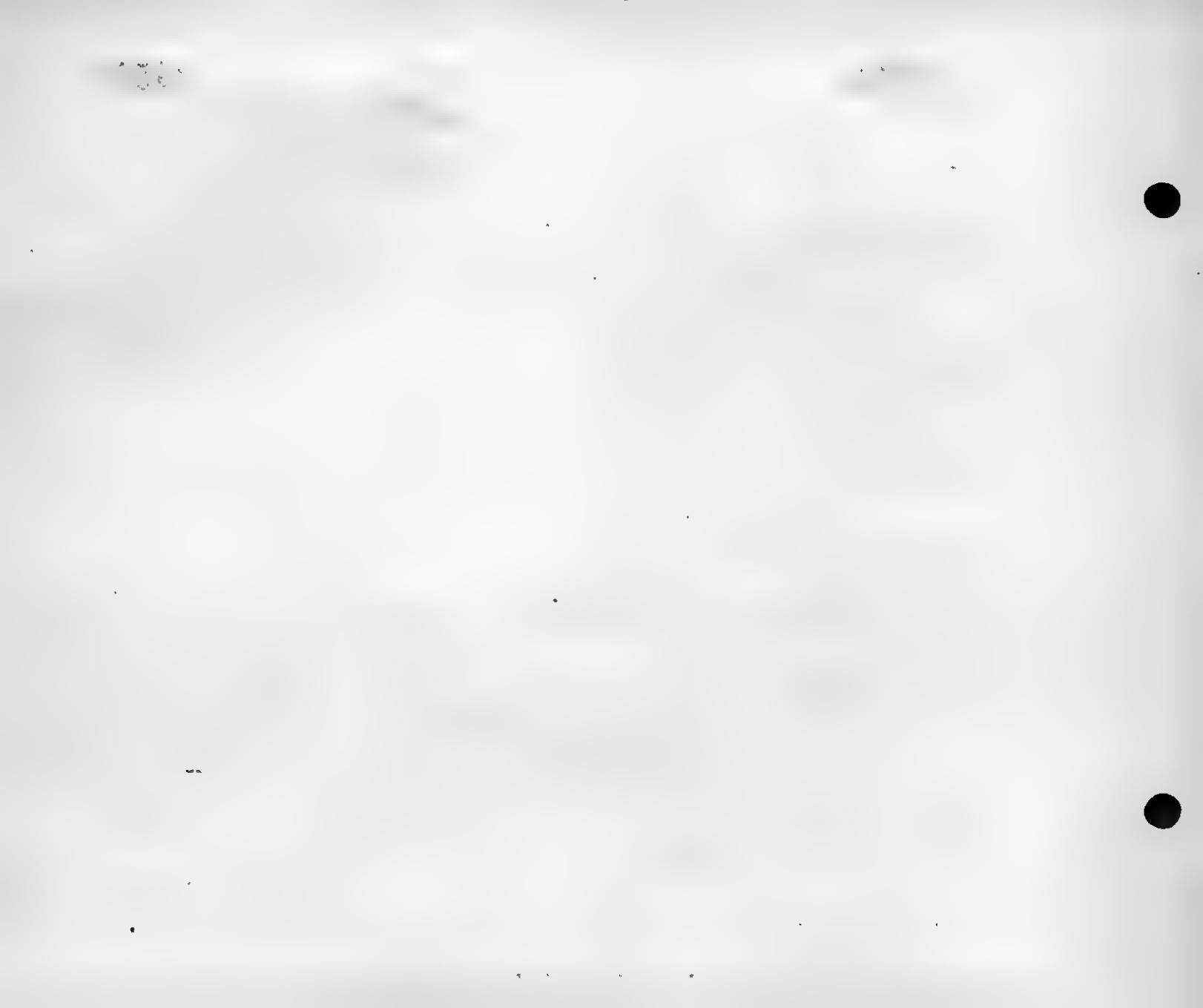
**CERTIFICATE OF DEATH**

17576

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or refrigeration, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>25 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital, Glenn Dale, Md.</b>			d. STREET ADDRESS <b>332 Channing St., N. E.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Essie A. Bonner</b>		First	Middle	Last	4. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>1966</b>
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11/23/1890</b>	9. AGE (In years last birthday) <b>76</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown (retired)</b>		10b. KIND OF BUSINESS OR IND.STRY <b>unknown</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>	
13. FATHER'S NAME <b>Thomas Joseph</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Malinda</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577-30-9457</b>		17. INFORMANT Address <b>Decedent</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Generalized arteriosclerosis and arteriosclerotic heart disease.</b> DUE TO (c) <b>unknown</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Glenn Dale Hospital</b>	(County) <b>Glenn Dale, Md.</b>
21. I certify that (s) (this hospital) attended the deceased from <b>12/5/1966</b> to <b>12/30/1966</b> , that (s) (we) last saw the deceased alive on <b>12/30/1966</b> , and that death occurred at <b>1:05 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/30/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		ADDRESS <b>300 4th, St. N.E. D.C.</b>	25a. REC'D BY REGISTRAR <b>JAN 5 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66		DATE			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17585

## CERTIFICATE OF DEATH

17577

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PG County.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 16 Days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland.		b. COUNTY Prince Georges.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital.		e. STREET ADDRESS 5610 Randolph St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edna May Boteler.		First		Middle		Lost		4. DATE OF DEATH 12	Month	Doy	Year
S SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-23-08	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Marly. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Edward Do West Boteler		14. MOTHER'S MAIDEN NAME Hattie I. Walker.		17. INFORMANT Hospital Records.		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 577 03 8427		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
				CARCINOMATOSIS							
				RENAL CARCINOMA		1 yr					
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	21. I certify that (I) (this hospital) attended the deceased from 12-4, 1966, to 12-20, 1966, that (I) (we) last saw the deceased alive on 12-20, 1966, and that death occurred at 7:20 P.M. from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE C. J. Houmann		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-20-66								
22c. PHYSICIAN'S NAME (Type) C. J. Houmann		22d. ADDRESS RIVERDALE MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 23, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Pro Geo Md.		(County)		(State)		
24. FUNERAL DIRECTOR F. Gaschi's Sons - Hyattsville, Md.		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE 12-27-1966		25b. REGISTRAR'S SIGNATURE					
VR A15 (4) 20 M 1/66											



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17586

## CERTIFICATE OF DEATH

17578

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>			b. COUNTY <b>PRINCE GEORGE'S</b>		
c. LENGTH OF STAY IN 16 <b>6 HR 54 MIN</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>			d. STREET ADDRESS <b>4662 HOMER AVENUE</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>LISA</b>	Middle <b>MICHELLE</b>	Last <b>BOUSMAN</b>	4. DATE OF DEATH <b>DECEMBER 31 1966</b>	Month Day Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED WIDOWED <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>30 DEC 1966</b>	9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months Days Hours Min <b>6 54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGE'S MARYLAND U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>DAVID PRESTON BOUSMAN</b>			14. MOTHER'S MAIDEN NAME <b>KAREN LEE BALLANCE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>N/A</b>		
17. INFORMANT <b>DAVID P. BOUSMAN - FATHER - SAME AS #2</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PREMATURITY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6HR 54MIN</b>		
7735 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RESPIRATORY DISTRESS SYNDROME</b>			6HR 54MIN		
DUE TO (c)					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>30 DEC 1966</b> , to <b>31 DEC 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>31 DEC 1966</b> , and that death occurred at <b>2:09 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Philip Steiner</i>			A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> M.D. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>PHILIP STEINER, CAPT, USAF, MC</b>			22d. ADDRESS <b>USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>			23b. DATE THEREOF <b>13 Jan 67</b>		
24. FUNERAL DIRECTOR <i>Craig J. Coffield</i>			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>D.C. MORGUE</b>		
25a. REC'D BY REGISTRAR DATE JAN 9 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17587

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit then please remove carbon papers Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>3 wks. 4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>10 D Southway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Theresa</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>Dec. 25 1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <b>Divorced</b>	NEVER MARRIED <input type="checkbox"/>	<input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-4-65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edward</b>		14. MOTHER'S MAIDEN NAME <b>Judith</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT <b>Edward H Bower</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>3103</b>		DUE TO <b>Menin G713 (Indeterminate Etiology)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 Days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>2) Pneumonitis</b>		<b>3) R. 0717154501A</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>66</b>	
21. I certify that (!) (this hospital) attended the deceased from <b>12-14, 1966</b> , to <b>12-25, 1966</b> , that (!) (we) last saw the deceased alive on <b>12-24, 1966</b> , and that death occurred at <b>30A</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Albert Roth</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Albert Roth</b>		22d. ADDRESS <b>Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 27, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ellivet Cemetery</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 29 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

17580

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6906 B St., Seat Pleasant, Md.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>6906 B St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lillian</b>		First <b>R.</b>	Middle <b>Boyer</b>	Last <b>Boyer</b>	4. DATE OF DEATH <b>December 2, 1966</b>	Month <b>December</b>	Day <b>2</b>	Year <b>1966</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1915</b>	9. AGE (In years last birthday) <b>54</b> yrs	10. UNDER 1 YEAR Months <b>0</b>	11. UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>	13. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Crider</b>					14. MOTHER'S MAIDEN NAME <b>? Horner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO			17. INFORMANT <b>Robert D. Boyer 6906 B St. Seat Pleasant Md.</b>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>190.1</b> (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Charles Town</b>		(County) <b>West Virginia</b>	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>1400</b> , 19 <b>66</b> , to <b>1400</b> , 19 <b>66</b> ; that (I) (we) last saw the deceased alive on <b>11/30</b> , 19 <b>66</b> , and that death occurred at <b>2E20 M.</b> from causes and on the date stated above.									
22a. SIGNATURE <i>Peter H. Duus</i>			M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> AM MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/2/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Duus, Peter, M.D.</b>			22d. ADDRESS <b>6124 Central Ave., Capitol Hgts, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Edge Hills Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Charles Town, West Virginia</b>			
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>				25a. RECEIVED BY REGISTRAR <b>DEC 6 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
4308 Suitland Road, Suitland Md.									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17589

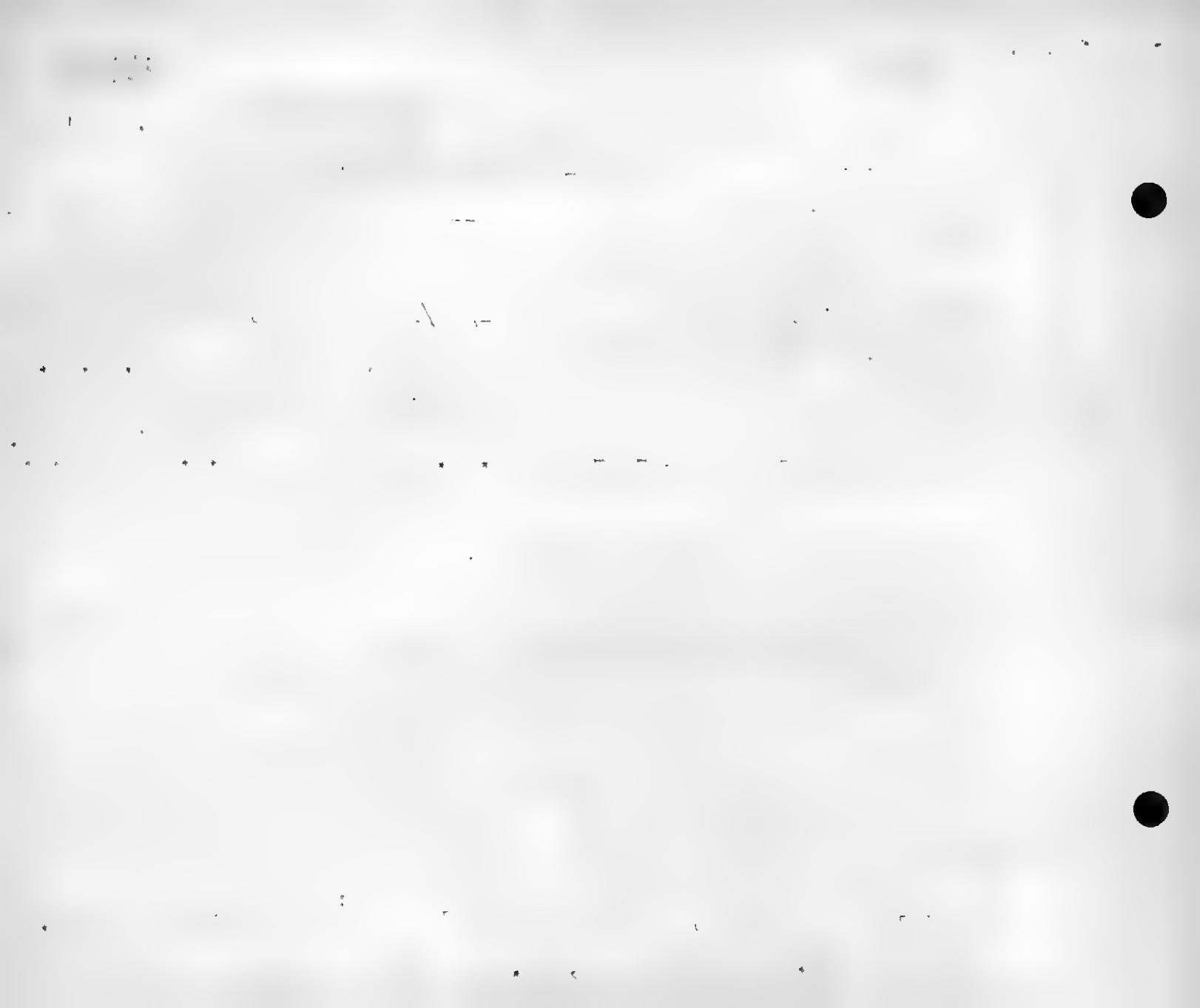
CERTIFICATE OF DEATH

17581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. This page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN b. <b>6 Mos-15 Days</b> Ritchie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>		d. STREET ADDRESS ---	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Alma</b>	Middle <b>Josephine</b>	Last <b>Brady</b>
4. DATE OF DEATH	Month <b>12</b>	Day <b>27</b>	Year <b>1966</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>No</b>	9. AGE (In years last birthday) <b>86 yrs</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Croome, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	13. FATHER'S NAME <b>William Beall</b>		
14. MOTHER'S MAIDEN NAME <b>Henrietta Elizabeth Hardy</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>217-46-5334</b>	17. INFORMANT <b>Dr. W. Suit Ritchie-S.E. Wash 27, D.C.</b>
18. CAUSE OF DEATH (Enter on y one cause per line, far (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOSCLEROSIS, Generalized</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Embolys Left Femoral Artery 12 hrs</b>			
20a. ACCIDENT WAS UNDER, YING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		
20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) <b>12-27-66</b>	(County) <b>1966</b>
21. I certify that (I) (this hospital) attended the deceased from <b>6-11</b> , 19 <b>66</b> to <b>12-27</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-26</b> , 19 <b>66</b> , and that death occurred at <b>5:57 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>WB Shear</b>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>
22b. DATE SIGNED <b>12-27-66</b>	22c. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEAR, M.D.</b>		
22d. ADDRESS <b>6400 MARLBORO PIKE S.E. WASH. D.C.</b>	23. METHOD OF BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		
23b. DATE THEREOF <b>12/29/66</b>	23c. METHOD OF BURIAL, CREMATION, REMOVAL (Specify) <b>Methodist Church Com.: Forest Memorial</b>		
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	(County) <b>Md.</b> (State)



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17590

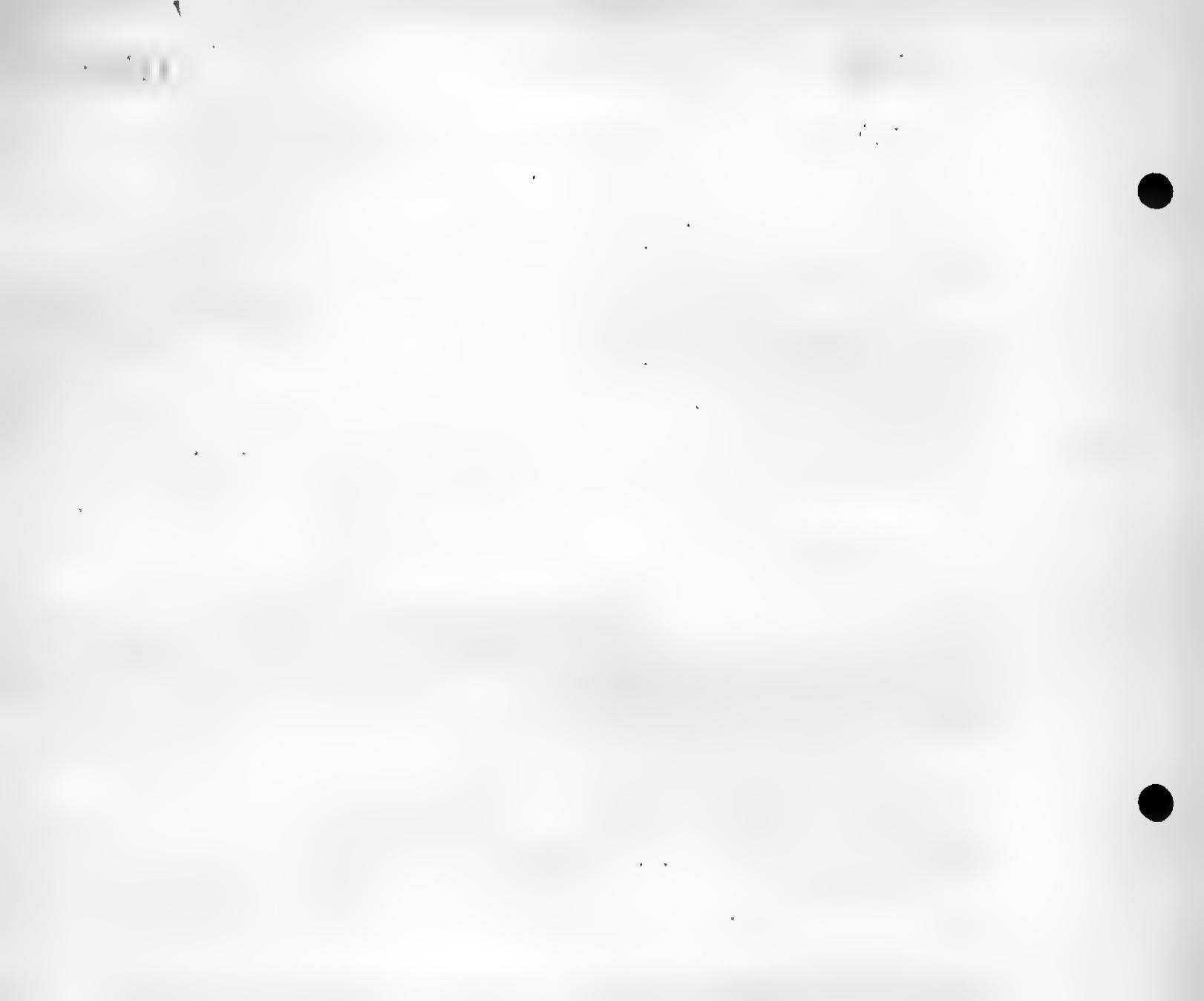
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17582

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>Md.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>30 min.</b>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		d STREET ADDRESS <b>12007 White Hall Drive</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George Hos.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Leo Joseph Brett</b>		First <b>Leo</b>	Middle <b>Joseph</b>
4 DATE OF DEATH Month <b>12</b>		Month <b>21</b>	Day Year <b>19 66</b>
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <b>1 May 1898</b>		9 AGE (In years last birthday) <b>68 yrs</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired detective</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11 BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Joseph F. Brett</b>		14 MOTHER'S MAIDEN NAME <b>Maryon G Brett</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes give war or dates of service <b>WW 1</b>		16 SOCIAL SECURITY NO <b>072 05 9484</b>	
17 INFORMANT <b>Maryon G Brett Bowie, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause lost <b>Arteriosclerotic heart disease</b> DUE TO <b>62X (c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Aneurism of thoracic aorta</b>		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c TIME OF INJURY Month, Day, Year Hour a.m. 9 a.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>12-25-66</b>	
ACTUAL SIGNATURE <i>John F. Brett</i> EXAMINER'S NAME (Type) <b>John F. Brett, M.D., Rivertown</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Phillipsburg New York</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Dec 28, 1966</b>	23c NAME OF CEMETERY OR CREMATORIUM <b>Wallkill Cemetery</b>
24 FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
		25a REC'D BY REGISTRAR <b>DEC 29 1966</b>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1759:

CERTIFICATE OF DEATH

17583

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. Hold in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEO</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>Ind.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN lb <b>16 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>2106 DEXTER AVE.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL MANOR</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>MARY E BREWER</b>		First <b>MARY</b>	Middle <b>E</b>
4 DATE OF DEATH <b>DEC. 15 1966</b>	Month <b>Dec.</b>	Day <b>15</b>	Year <b>1966</b>
5 SEX <b>FEM</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12/13/1891</b>	9 AGE (In years last birthday) <b>75 yrs</b>	10. IF UNDER 1 YEAR Months <b>—</b>	11. IF UNDER 24 HRS Days <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>WASH. D.C.</b>	
13. FATHER'S NAME <b>THEODORE A. BURNS</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mobray</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-38-6846</b>	17. INFORMANT Address <b>SR. CHRISTINE - CARROLL MANOR</b>
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Hyperensive Arteriosclerotic Cardiovascular Disease</b>			
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>		(County) (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12-13 1966</b> to <b>12-14 1966</b> , thot (I) (we) last saw the deceased alive on <b>12-13 1966</b> , and that death occurred at <b>1134 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Bernard A. Fitzgerald</b>		22b. DATE SIGNED <b>12-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD A. FITZGERALD</b>		22d. ADDRESS <b>217 UNION BLVD E SILVER SPRING MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>17 DEC. 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>GATE OF HEAVEN CEMETERY</b>
23d. LOCATION (City or Town) <b>SILVER SPRING MD</b>		(County) (State) <b>—</b>	
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home, Inc. 7400 Georgia Ave.</b>		ADDRESS <b>DC 20012</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 3 1-15-66 MH

17592

## CERTIFICATE OF DEATH

17584

~~Death certificate to be executed within 24 hours after death.~~

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md.</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		e. STREET ADDRESS <i>4111 East West Highway</i>	
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4111 East West Highway</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ella F. Brueckner</i>		4. DATE OF DEATH Month <i>Aug</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9. DATE OF BIRTH <i>June 6, 1889</i>	
10a. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		9. AGE (In years last birthday) <i>77 years</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Elan Foley</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bundy</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-28-1938</i>	
17. INFORMANT <i>Arthur L. Brueckner Hyattsville, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the colon</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>with metastasis to liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>	
(b) DUE TO <i></i>			
(c) DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerotic heart disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Aug 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1746 Rock N.W. Washington D.C.</i>
20f. (City or town) <i>Colmar Manor</i>		(County) (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> , 19 <i>66</i> , to <i>12/7</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/6</i> , 19 <i>66</i> , and that death occurred at <i>2:30 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>S. W. Nealon Jr</i>		22b. DATE SIGNED <i>12/7/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>S. W. NEALON, JR</i>		22d. ADDRESS <i>1746 Rock N.W. Washington D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombment</i>		23b. DATE THEREOF <i>Dec 9, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft Lincoln Mausoleum</i>
23d. LOCATION (City or Town) <i>Colmar Manor</i>		(County) (State) <i>Pro Geo Md.</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	25a. REC'D BY REGISTRAR <i>DEC 8 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## **CERTIFICATE OF DEATH**

17585

17593

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 4 hours after death.

VR A15 (4)  
20 M 1/6

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 13, 14, Form 384, 14-27/66 mh

CERTIFICATE OF DEATH

17585

17593

1 PLACE OF DEATH  
a. COUNTY Prince George MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Cheverly

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
Adsocorda Nursing Home

3. NAME OF  
DECEASED  
(Type or print)

First CONSTANCE

Middle F.

Last BUTTERS

4. DATE  
OF  
DEATH Dec.

Month

Doy

Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED  NEVER MARRIED  b. DATE OF BIRTH Feb. 18, 1909 9. AGE (in years last birthday) 57 yrs

10a. USUAL OCCUPATION (Give kind of work done during last year, life even if retired)  
Cafe Helper 10b. KIND OF BUSINESS OR INDUSTRY School

11. BIRTHPLACE (County & State, or foreign country)  
Pennsylvania

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME Joseph Butters Parcheski

14. MOTHER'S MAIDEN NAME Poreda  
Frances S. Pareda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  16. SOCIAL SECURITY NO. 025 05 3543 17. INFORMANT Address

George K. Butters Same as #2 (husband)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY.  
IMMEDIATE CAUSE (a)

INTERVAL BETWEEN  
ONSET AND DEATH  
over 6 Mon

19.2.0  
DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b)

DUE TO  
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AN AUTOPSY PERFORMED?  
YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o.m.  
p.m. 19

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20e. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 2, 1966, to Dec 10, 1966, that (I) (we) last saw the deceased alive on Dec 9, 1966, and that death occurred at 11:30 AM, from causes and on the date stated above.

22a. SIGNATURE John Kehoe, M.D.

22b. DATE SIGNED 12/10/66

22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.

22d. ADDRESS 6300 Riverdale Road Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 12/13/66

23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven

23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.

24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.

25a. REC'D BY REGISTRAR Charles Judge

ADDRESS

25b. REGISTRAR'S SIGNATURE

DATE DEC 15 1966



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17594

## CERTIFICATE OF DEATH

17587

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 7701 Arshert Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First: Edward S.	Middle: Cauffman	4. DATE OF DEATH Dec. 15 19 66
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 13 Mar., 1902
9. AGE (in years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ANNXXXXXXHOWARD CAUFFMAN		14. MOTHER'S MAIDEN NAME ANNIEBELL PIERCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Pulmonary Insufficiency</u>			
INTERVAL BETWEEN ONSET AND DEATH			
165 X		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Congestion of lungs</u>	
{		DUE TO	
last.		(c) <u>Pulmonary Edema</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/1/66, 19 to 12/15, 19 66 that (I) (we) last saw the deceased alive on 12/15 19 66, and that death occurred at 2:45 AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Edwin J. Jensen, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Geo. Gen. Hosp., Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/17/66	
		23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY	
23d. LOCATION (City or Town) (County) (State)		PRINCE GEORGES, MARYLAND	
24. FUNERAL DIRECTOR WILHELM FUNERAL HOME ADDRESS 4308 SUITLAND RD, SUITLAND MD.		25a. REC'D BY REGISTRAR Date DEC 22 1966	
		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

17595

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17588

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE - b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.	
c. LENGTH OF STAY IN 1b 40 minutes		d. STREET ADDRESS 1724 Corcoran St., N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Alfred	Middle Ennio	Last Cavicchia
4. DATE OF DEATH 12 6 1966	Month Day Year		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical		9. AGE (In years last birthday) 24 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY student		11. BIRTHPLACE (State or foreign country) New York City	
13. FATHER'S NAME Ennio Cavicchia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 059 34 2325	
17. INFORMANT Lynn H Cavicchia New York City N.Y.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple skull fractures DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. driver of car involved in collision		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) White at work <input type="checkbox"/> Not White at work <input checked="" type="checkbox"/> Routes 301 & 381 Prince George's, Md.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:01 p.m. 12-5 1966		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 12-6-66	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 10, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM Moravian Cemetery		23d. LOCATION (City, town or county) (State) Staten Island New York.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE DEC 8 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17596

CERTIFICATE OF DEATH

17589

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>			
c. LENGTH OF STAY IN lb <b>1 day</b>				d. STREET ADDRESS <b>4501 32nd Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Geprges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Lester</b>	Middle <b>E</b>	Lost	4. DATE OF DEATH Month <b>Dec.</b>	Day <b>27</b>	Year <b>1966</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11 Sept., 1903</b>	9. AGE (In years lost birthday) <b>63 yrs</b>	11. IF UNDER 1 YEAR Months <b>0</b>	12. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H/W</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Durham, North Carolina</b>	
13. FATHER'S NAME <b>Jerome Freeman</b>			14. MOTHER'S MAIDEN NAME <b>Lottie Holder</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) If yes give war or dates of service <b>No</b>			16. SOCIAL SECURITY NO. <b>Unk.</b>			17. INFORMANT <b>Doyle E. Cherry</b>	
<b>4501 Address</b> <b>32nd Street</b> <b>Mt. Rainier, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE Emphysema &amp; minor plugging of bronchios</b> DUE TO <b>x71</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last DUE TO DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) <b>Durham</b>	(County) <b>North Carolina</b>	(State) <b>USA</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 27, 1966</b> , to <b>Dec. 28, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec. 28, 1966</b> , and that death occurred at <b>4:25 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Robert T. Kelley</i>		M.D. ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <b>12/28/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Kelley, M.D.</b>		22d. ADDRESS <b>1026 16th St., N.W., Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		23b. DATE THEREOF <b>12/31/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Memorial</b>		23d. LOCATION (City or Town) <b>Durham</b>	(County) <b>North Carolina</b>	(State) <b>USA</b>
24. FUNERAL DIRECTOR <b>Murphy Funeral Home</b>		ADDRESS <b>John C. Thomas</b>	ARLINGTON, VIRGINIA	25a. REC'D. BY REGISTRAR DATE <b>DEC 30 1966</b>	25b. REGISTRAR'S SIGNATURE <b>John C. Thomas</b>		



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17597

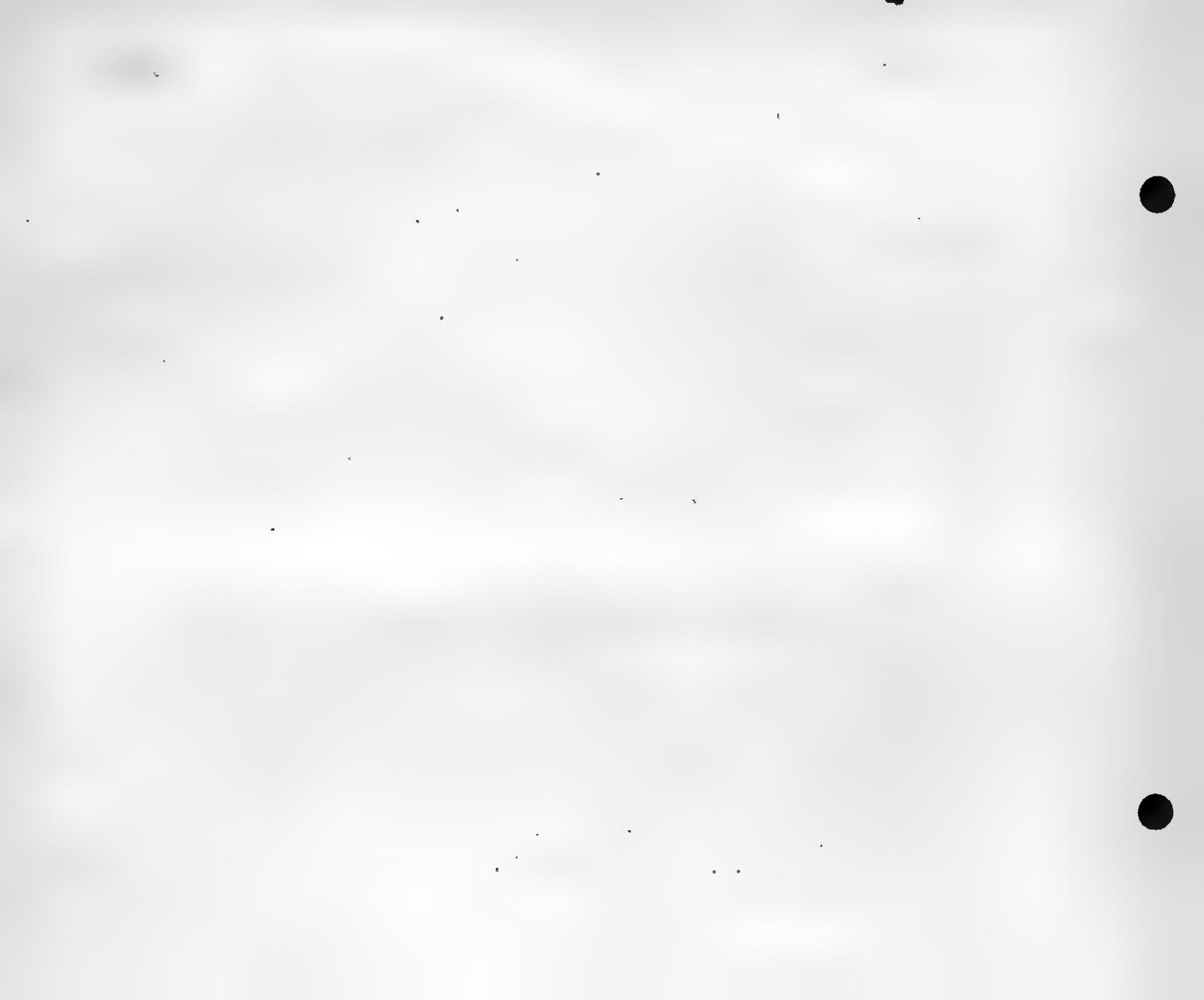
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17598

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 5 Hrs.		d. STREET ADDRESS 6503 C. Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William A	Last Chisholm	Month 12 Day 7 Year 1966
4. DATE OF DEATH	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 28 Nov. 1887	9. AGE (In years last birthday) 79 yrs.	10. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Minn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Angus Chisholm	14. MOTHER'S MAIDEN NAME Elizabeth Quigley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 468-14-8005A	17. INFORMANT Margaret C. Chisholm	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nutritional cirrhosis of liver with hepatic failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type) Riverdale, Md.			
22. DATE SIGNED 12-9-66		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 13, 1966	23c. NAME OF CEMETERY OR CREMATORI St. Mary's	23d. LOCATION (City, town or county) (State) Minneapolis, Minn.
24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St. Ne. Wash.	ADDRESS	25a. REC'D BY REGISTRAR DEC 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

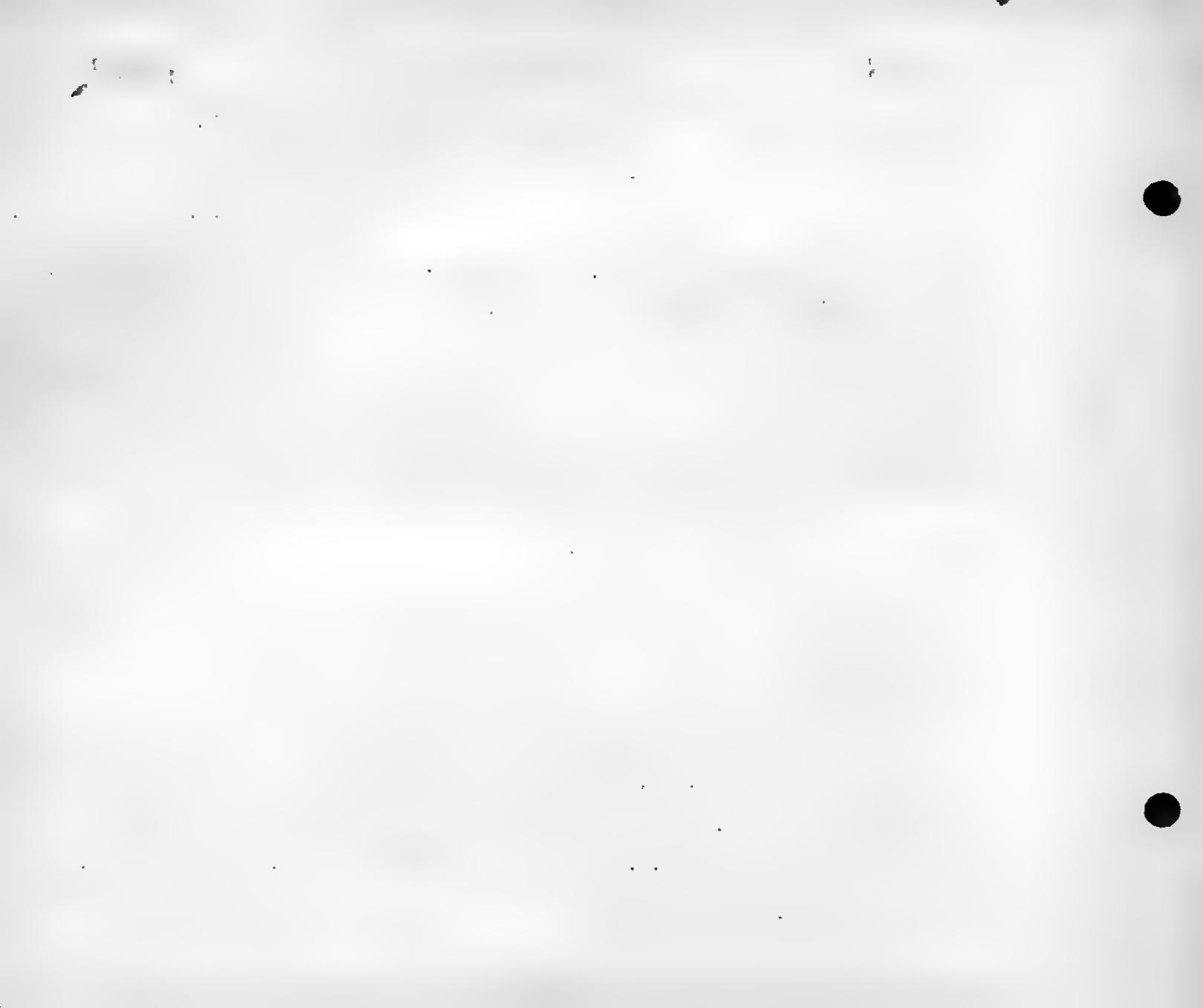
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17598

**CERTIFICATE OF DEATH**

17591

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clevelevy</b>			b. COUNTY <b>Prince George's</b>		
c. LENGTH OF STAY IN lb <b>19 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>=Washington, D. C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>2806 Channing St., N.E.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Horace</b>	Middle <b>R.</b>	Last <b>Clopton</b>	4. DATE OF DEATH Month <b>December 27</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/18</b>
10a. U.S. OCCUPATION (G ve kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years 48 last birthday) yrs.	
13. FATHER'S NAME <b>Arthur Clopton</b>		11. BIRTHPLACE (County & State, or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clydie Clopton</b> Same as 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>Bilateral severe pulmonary congestion &amp; edema</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>581.0</b>		DUE TO (b) <b>Hepatic failure</b>			
		DUE TO (c) <b>Severe nutritional fatty infiltration of liver</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>12:20 P.M.</b>	
20f. (City or town) <b>Baltimore</b>		(County) <b>Maryland</b>		(State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 27, 1966</b> , to <b>Dec. 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 27, 1966</b> , and that death occurred at 12:20 P.M. from causes and on the date stated above.					
22a. SIGNATURE <b>Till Bergemann</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Till Bergemann, M.D.</b>		22d. ADDRESS <b>Professional Bldg., Greenbelt, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-31-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Sun Set Mem. Co.</b>	
24. FUNERAL DIRECTOR <b>Lester Bergemann</b>		ADDRESS <b>1211 1/2 E. 10th Street</b>		25a. REC'D. BY REGISTRAR <b>DEC 28 1966</b>	
				DATE <b>1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Till Bergemann</b>					



FOR STATE  
HEALTH DEPT.

necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17589

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17592

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DCA		c. LENGTH OF STAY IN 1b DCA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS RFD Box 2085		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First: Angela Middle: Renea Surname: Colbert		4. DATE OF DEATH 12 21 19 66		Month Day Year	
5. SEX Female Negro		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 7-12-66		9. AGE (In years lost birthday) yrs 5		10. UNDER 1 YEAR Months Days Hours Min.	
10. U.S. OCCUPATION (Give kind of work done during most or working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME James Colbert			14. MOTHER'S MAIDEN NAME Sadie Belt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT James Colbert Upper Marlboro, Md.	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia, right upper lobe</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SDII</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect'an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED 12-22-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-24-66		23c. NAME OF CEMETERY OR CREMATORIAL Moses Cemetery	
23d. LOCATION (City or Town) Anne Arundell, Md.		(County) (State)			
24. FUNERAL DIRECTOR Rollins Funeral Home, Inc. Pl., N.E.		ADDRESS 4339 Hunt		25a. REC'D BY REGISTRAR REC 27 1966	
25b. REGISTRAR'S SIGNATURE James Judge					
6-200224					



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17593

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return them to you within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN 1b <b>50 MIN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
e. STREET ADDRESS <b>3401 15TH STREET S.E.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GLENIECE</b>		First <b>VENETTA</b>	Middle <b>COLKLEY</b>
Last <b>DECEMBER</b>		Month <b>4</b>	Day <b>19</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGROID</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>28 JUNE 1965</b>		9. AGE (In years last birthday) 1 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Dey <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY LEE COLKLEY</b>		14. MOTHER'S MAIDEN NAME <b>LORRAINE REBECCA NEAL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>HARRY L. COLKLEY-FATHER-SAME AS #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>872.0</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Salicylate intoxication</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Took overdose of aspirin</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>PM</b> 12-4 19 <b>66</b>		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Same as #2</b>		(County) <b>Same as #2</b>	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JOHN J KEHOE, M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>5 DEC 1966</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/8/66</b>		23b. DATE THEREOF <b>12/8/66</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nook</b>		23d. LOCATION (City, town or county) <b>Arlington, VA</b>	
24. FUNERAL DIRECTOR <b>W.L. Combs</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>DEC 8 1966</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17601

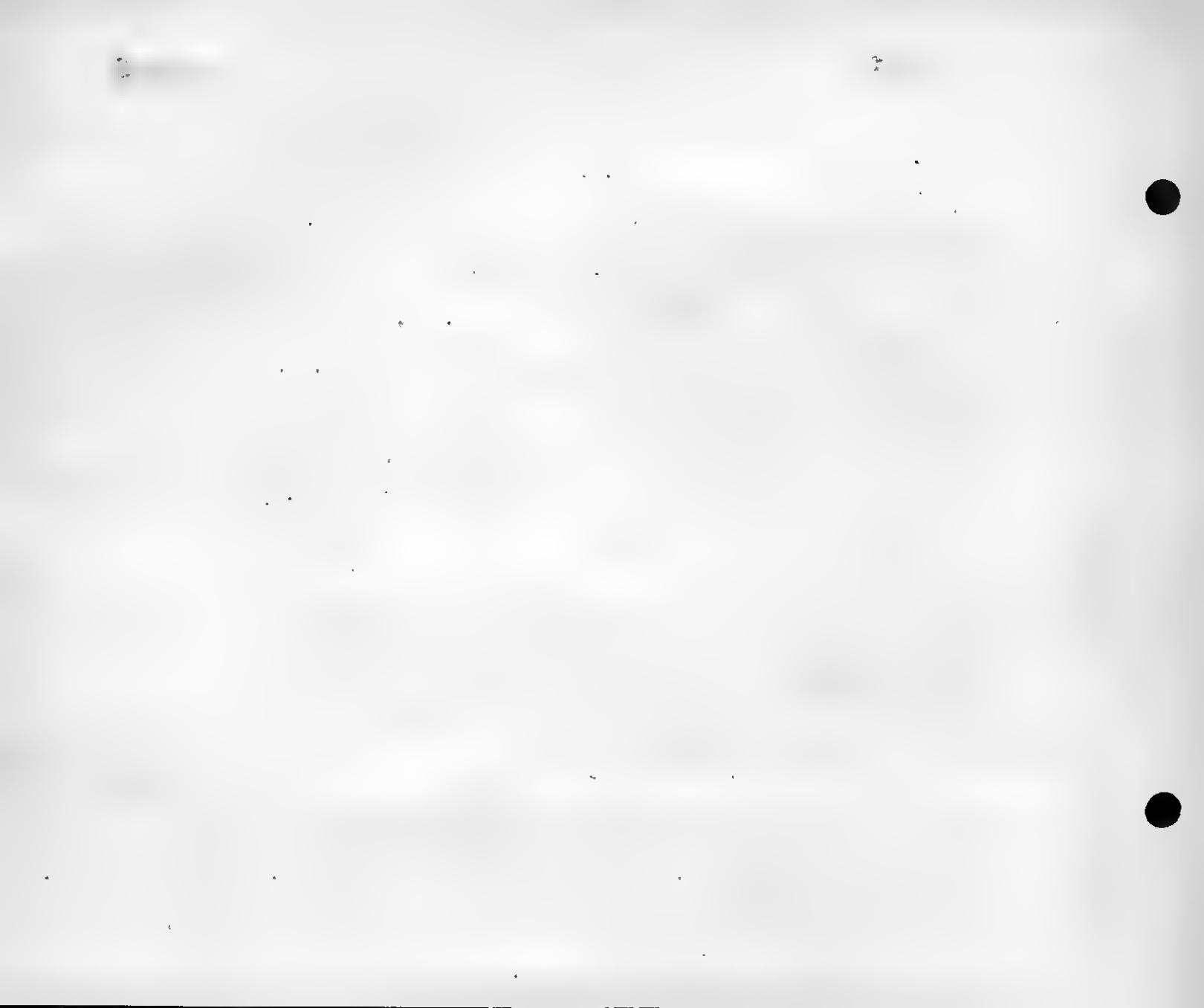
CERTIFICATE OF DEATH

17594

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b>		d. STREET ADDRESS <b>4902 F St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
NAME OF DECEASED (Type or print)		First <b>John</b>	Middle <b>L.</b>	Lost <b>Compher</b>	4. DATE OF DEATH <b>December 17,</b>	Month <b>1966</b>	Day <b>19</b>	Year <b>66</b>	
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 27, 1901</b>	9 AGE (In years 65 lost birthday) yrs.	10 IF UNDER 1 YEAR Months <b>0</b>	11 IF UNDER 24 HRS Days <b>0</b>	12 Hours <b>0</b>	13 Min <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>			10b KIND OF BUSINESS OR INDUSTRY			11 BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William E. Compher</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Decator</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>NO</b>			16. SOCIAL SECURITY NO			17. INFORMANT <b>Catherine W. Compher 4902 F Street</b>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute coronary occlusion</i>									INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) <i>Arteriosclerotic coronary- art disease 10 yrs.</i>						
			DUE TO (c) <i>Arteriosclerotic cardiac vascular disease 10 yrs.</i>						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 12-17, 1966, that (I) (we) last saw the deceased alive on 12-15 1966, and that death occurred at _____ M, from causes and on the date stated above.									
22a. SIGNATURE <i>Peter Duus</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>Peter Duus, M.D.</b>			22d. ADDRESS <b>6124 Central Ave., Capitol Hgts., Md.</b>						
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE THEREOF <b>12/20/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Maryland</b>		
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>			ADDRESS <b>4308 Suitland Rd. Suitland Md.</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66						DATE DEC 21 1966			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

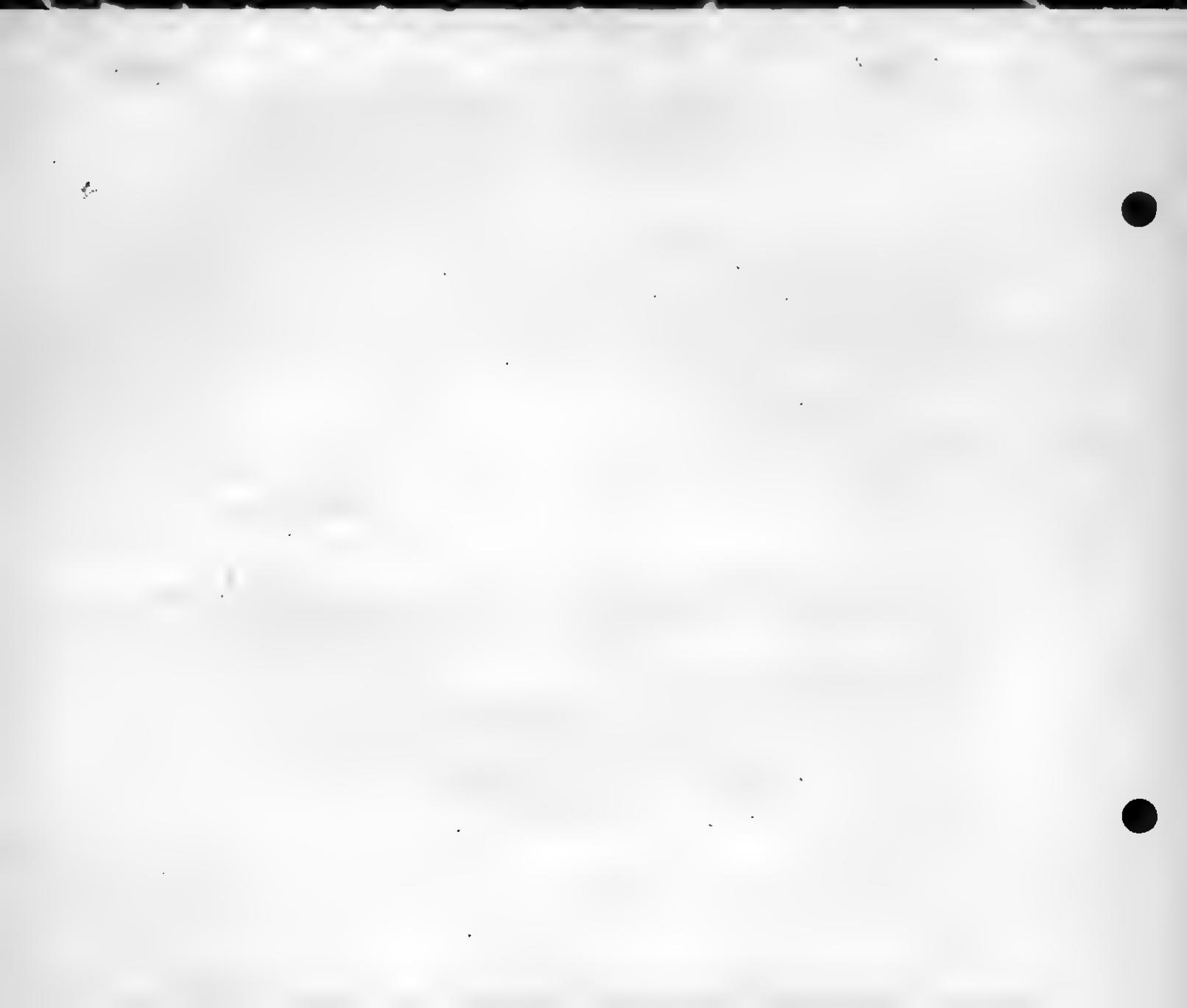
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

Item 8 Film 6504

**17802** **17595**

1. PLACE OF DEATH ■ COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Prince George's Maryland		b. STATE Washington DC b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hosp		d. STREET ADDRESS 11 Riggs Rd NE		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Thomas	Middle A. Costello	Last Dec 16 1966	
4. DATE OF DEATH	Month Dec	Day 16	Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/95	
9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (County & State, or foreign country) Wash D.C.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John C.	14. MOTHER'S MAIDEN NAME Mary Carmody	Address Viola Maria Costello. (life)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Coronary Artery Disease Hypertensive Cardiovascular Disease	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19				
21. I certify that (I) (this hospital) attended the deceased from 1955 to Dec 16, 1966, that (I) (we) last saw the deceased alive on Oct 22 1966, and that death occurred at 11 AM, from the causes and on the date stated above.				
22a. SIGNATURE Richard L. Whetton		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Richard L. Whetton		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 1017 University Blvd E Silver Spring MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 20 66	23c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	23d. LOCATION (City, town or county) (State) VA.
24. FUNERAL DIRECTOR Harlan Funeral Home		ADDRESS 4747 Wisc Ave NW	25a. REC'D BY REGISTRAR Jan 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17603

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17596

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>	
f. STREET ADDRESS <b>2105 Charleston Lane</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Cassilda</b>		First <b>Lillian</b>	Middle <b>Crawford</b>
4. DATE OF DEATH <b>32</b>	Month <b>25</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <b>X</b> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-8-08</b>
9. AGE (In years last birthday) <b>58 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. F UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work no lie, even if retired) <b>Transcriber- Nat'l. Geographic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Maine</b>	11. BIRTHPLACE (State or foreign country) <b>Maine</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Howard Murch</b>	14. MOTHER'S MAIDEN NAME <b>Lula Bunker</b>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <b>No.</b>	16. SOCIAL SECURITY NO <b>577-07-0592</b>	17. INFORMANT <b>John D. Crawford, See Item No. 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am pm <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>12-25-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington, Nat'l. Cen.</b>
23d. LOCATION (City or Town) (County) (State)		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Joseph Taylor's Sons, Inc. 5130 1/2 visc. Ave. N.W. Wash. DC.		25a. ADDRESS	25b. REC'D BY REGISTRAR DEC 29 1966
		25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17604

## CERTIFICATE OF DEATH

17597

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 16 <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Florence</b>	Middle <b>Creighton</b>	4. DATE OF DEATH Month <b>December</b> Day <b>15, 19 66</b>
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>NEVER MARRIED</b>	B. DATE OF BIRTH <b>4/4/78</b>
10a. US/JAL OCCUPATION (Give kind of work done during most recent job, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Owens</b>		14. MOTHER'S MAIDEN NAME <b>Susanna Frederica Sapp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Dorothy Fastnaught Same as #2 (daughter)</b>	
17. INFORMANT <b>Dorothy Fastnaught Same as #2 (daughter)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MASSIVE INFARCTION OF MYOCARDIUM (ANT. WALL OF LT VENTRICLE) WITH ANEURYSMAL DILATATION</b> + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CORONARY THROMBOSIS (ANT DESCENDING LT CORONARY)</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? <b>XXX NO</b>			
MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 12, 1966</b> , to <b>Dec. 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 15, 1966</b> , and that death occurred at 9:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Robert T. Kelley, M.D.</i>		22b. DATE SIGNED <b>12/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Kelley, M.D.</b>		22d. ADDRESS <b>1026 16th St., N.W., Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/19/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>
24. FUNERAL DIRECTOR <i>Haas Funeral Home</i>		ADDRESS <i>4739 Belts, Ave., Hyattsville, Md.</i>	25a. RECD BY REGISTRAR <b>P.G.</b>
			25b. REGISTRAR'S SIGNATURE <i>Monley Judd</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17605

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17598

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY  Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution Reside before admission) a. STATE District of Columbia b. CO. CTY.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN lb DOA	c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Washington	d. STREET ADDRESS 3601 11th St., N.W.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Henry	4. DATE OF DEATH Month 12 22 1966 Day Year
5. SEX Male 16	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH 21 Jan., 1925 9. AGE (In years lost birthday) 41 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO WORKS		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GEORGIA
13. FATHER'S NAME JOHN H CUMMINGS		14. MOTHER'S MAIDEN NAME EULA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> Yes give war or dates of service		16. SOCIAL SECURITY NO.	17. INFORMANT EULA M. CUMMINGS, Address 3601 11TH ST. N.W.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral hemangioma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 181X (b) Gunshot wound of chest DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shot by assailant	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:00 p.m. 12 22 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Parking lot-1701 Kenilworth Ave., D.G., Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D., Riverdale	
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 1/24/66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington	
23d. LOCATION (City or Town) Md.		(County) (State)	
24. FUNERAL DIRECTOR Robert L. Kehoe		ADDRESS 1615-12 21st St. E	REC'D BY REGISTRAR REC'D BY REGISTRAR DATE DEC 29 1966
		25a. REG STRAPS SIGNATURE Charles J. Keohoe	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17549

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 hr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Asa Franklin</b>		First <b>Asa</b>	Middle <b>Franklin</b>
4. DATE OF DEATH Month <b>12</b>	Month <b>21</b>	Year <b>1966</b>	Doy Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>4 April 1905</b>		9. AGE (in years last birthday) <b>61 yrs</b>	
10. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio Repairman</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Asa F Davis</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes give war or dates of service <b>yes 1924 to 1928</b>		16. SOCIAL SECURITY NO. <b>Asa F Davis Jr Palmer Park, Md.</b>	
17. INFORMANT <b>Asa F Davis Jr Palmer Park, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
(b) DUE TO		unknown	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF MORT. Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF MORT. (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Suitland</b> (County) <b>Prince George's</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John K. Keay, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John K. Keay, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) <b>Suitland Pro Geo Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 27, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>
23d. LOCATION (City or Town) <b>Suitland</b> (County) <b>Prince George's</b> (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		ADDRESS	
		25a. RECEIVED BY REGISTRAR <b>DEC 29 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15ME (5) 6M 1/67			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17607													
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN TB <b>DOA</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. STREET ADDRESS <b>Hillside</b>									
3. NAME OF DECEASED (Type or print) <b>Thomas James Delany</b>				4. DATE OF DEATH <b>5102 Benning Road</b>									
First	Middle	Last	Month	Doy	Year								
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-14-1892</b>	9. AGE (In years last birthday) <b>74 yrs</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.						
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>									
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO				17. INFORMANT <b>Beatrice Delaney</b>					
								Address <b>5102 Benning Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Heart failure</b> INTERVAL BETWEEN Conditions, if any, which gave ONSET AND DEATH minutes rise to immediate cause (a). stating the underlying cause last. (b) DUE TO Arteriosclerotic heart disease over 1 yr. (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.				22. DATE SIGNED <b>12-26-66</b>					
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
Address (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Lincoln Memorial Ceme.</b>		23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>							
24. FUNERAL DIRECTOR <i>John T. Stewart</i>		ADDRESS <b>Stewart Funeral Home 4001 Benning Rd.</b>		25a. REG'D BY REGISTRAR <b>DEC 30 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>							
VR A15ME (5) 6M 1/67													



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17608

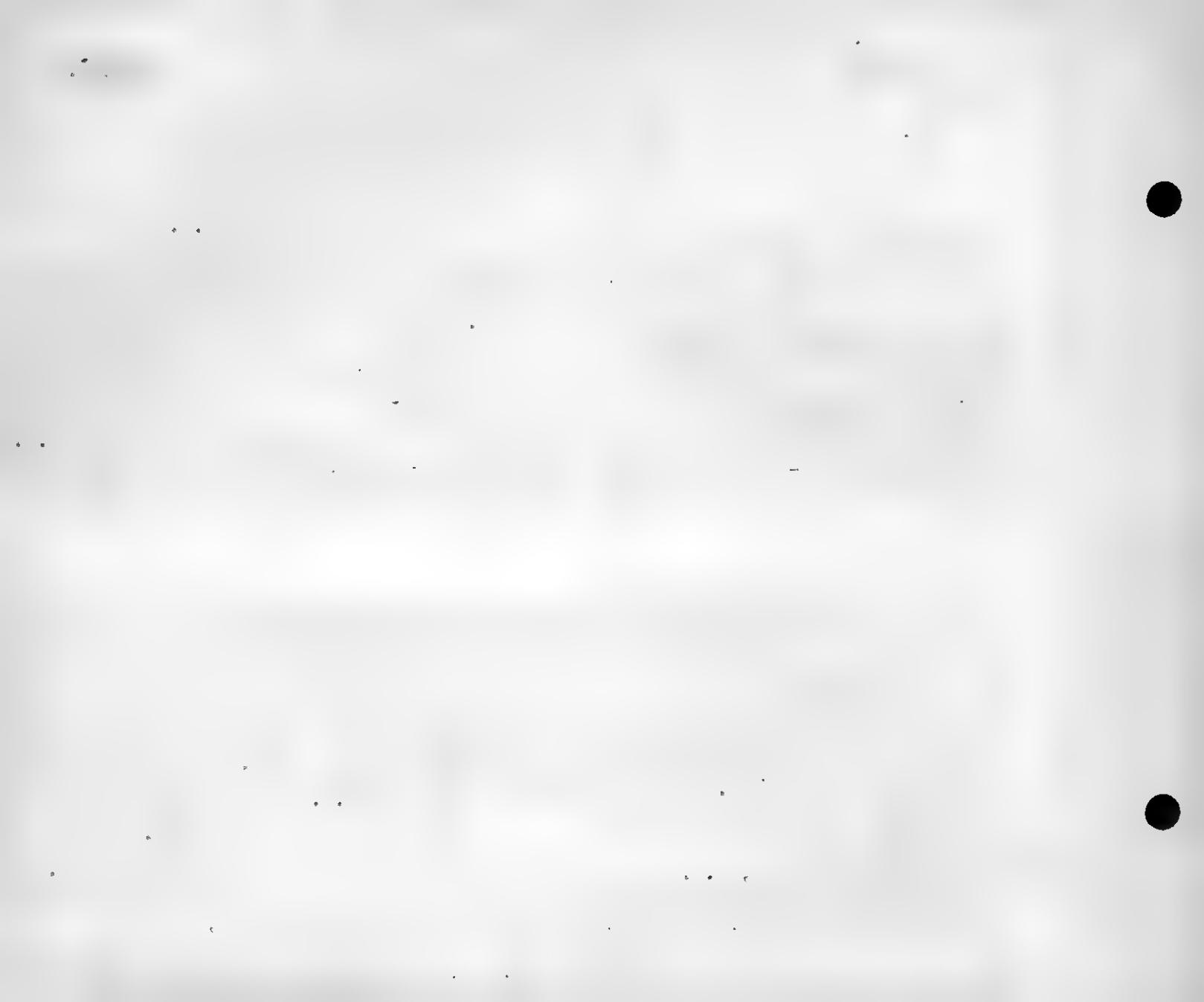
CERTIFICATE OF DEATH

17601

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if instit. on. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Glenn Dale)</b>		c. LENGTH OF STAY IN lb <b>26 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>402 Jefferson Street, N.E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Jerry</b>		First <b>A.</b>	Middle <b>Disandro</b>	4. DATE OF DEATH <b>December 11</b>	Month <b>1966</b>	Doy <b>19</b>	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1914</b>	9. AGE (In years lost birthday) <b>52</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. LSSU OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Foreign-born (unknown)</b>	
13. FATHER'S NAME <b>Gioeinto Disandro</b>			14. MOTHER'S MAIDEN NAME <b>Susanna ?</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Brother - Raymond Disandro</b>	Address <b>402 Jefferson Street, N.E.</b>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far Advanced</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
21 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>generalized arteriosclerosis</b>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>Dec. 11 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Washington, DC</b>	(County) <b>DC</b>	(State) <b>DC</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 15, 1966</b> , to <b>Dec. 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 11, 1966</b> , and that death occurred at <b>12:10 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	M.D. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <b>Dec. 11, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>14 Dec. 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) <b>Washington, DC</b>	(County) <b>DC</b>	(State) <b>DC</b>	
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home</b>		ADDRESS <b>7400 Georgia Ave., N.W.</b>	25a. REC'D BY REGISTRAR <b>DEC 20 2012</b>	25b. REGISTRAR'S SIGNATURE <b>DEC 14 2012 M. Charles Judge</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17609

**CERTIFICATE OF DEATH**

17602

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional- Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>PRINCE GEORGE'S</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b>		c. LENGTH OF STAY IN lb <b>27 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		d. STREET ADDRESS <b>CEDARVILLE MOBILE HOME PARK</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>CEDARVILLE MOBILE HOME PARK</b>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CARYLON</b>		First <b>LYNN</b>	Middle <b>DIXON</b>	Last	4. DATE OF DEATH DECEMBER 31 1966	Month	Day	Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 DEC 1966</b>	9. AGE (In years last birthday) yrs <b>27</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUA OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGE'S MARYLAND U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>THOMAS JAMES DIXON</b>		14. MOTHER'S MAIDEN NAME <b>CHUNG SUI KIM</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>N/A N/A</b>		17. INFORMANT <b>THOMAS J DIXON-FATHER-SAME AS #2</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>776X</b>		IMMEDIATE CAUSE (a) <b>PREMATURE</b> DUE TO <b>b</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>c</b>				INTERVAL BETWEEN ONSET AND DEATH <b>27 MIN</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>ANDREWS AFB</b>		(County) <b>WASHINGTON DC</b> (State) <b>20331</b>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>31 DEC 1966</b> , to <b>31 DEC 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>31 DEC 1966</b> , and that death occurred at <b>7:15 M</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>ROGER E SPITZER</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		P.M. STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>31 DEC 66</b>		
22c. PHYSICIAN'S NAME (Type) <b>ROGER E SPITZER, CAPT USAF MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5 JAN. 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>		
24. FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b>		ADDRESS <b>4308 SUITLAND ROAD, SUITLAND MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>G. L. Kelly's Judge</b>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17610

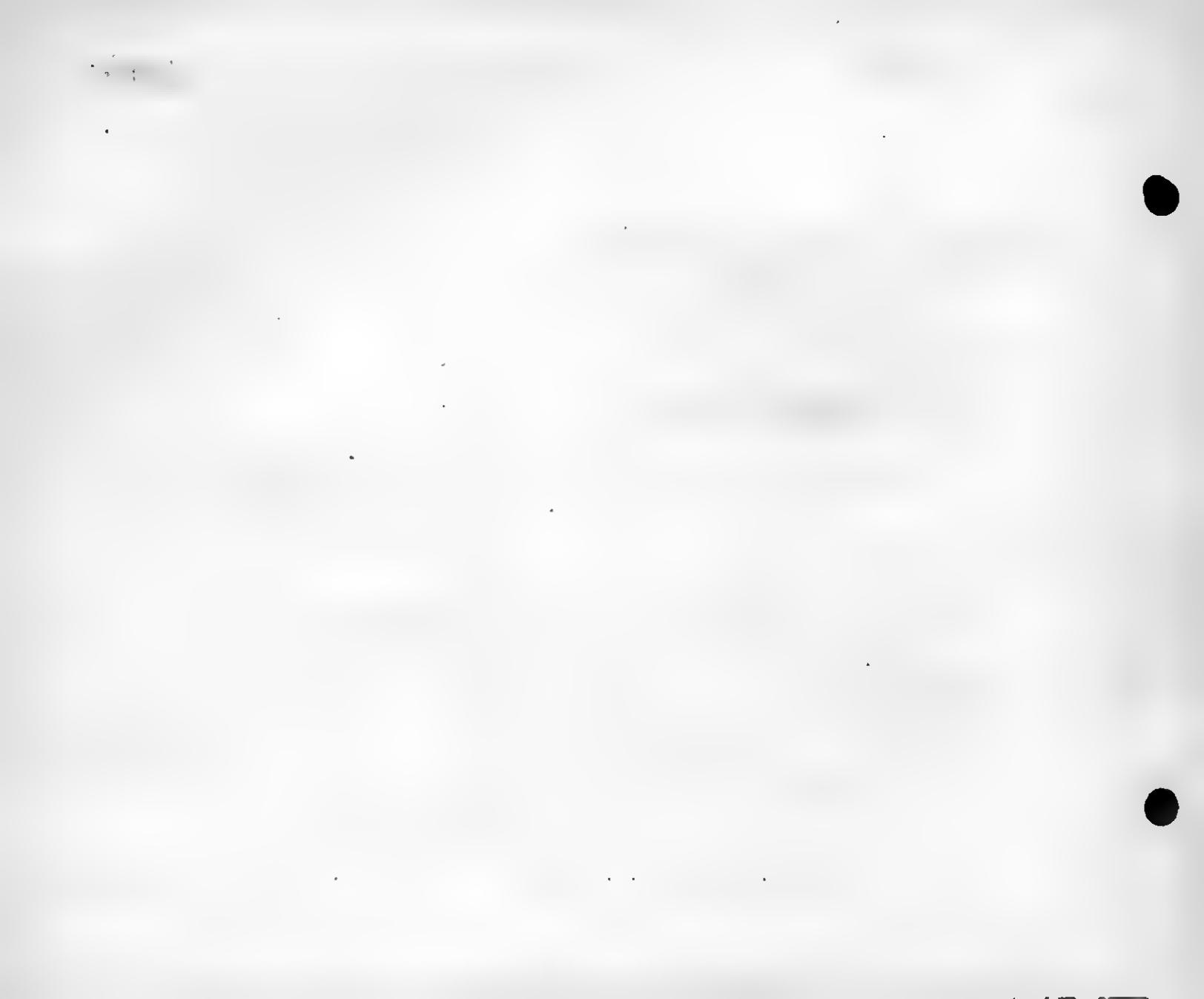
## CERTIFICATE OF DEATH

17603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			b. COUNTY <b>Prince George's</b>		
c. LENGTH OF STAY IN b <b>10 hours</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>61 Gibbons Church Road</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Viola Elizabeth Elizabeth Driver</b>			4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1966</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
8. BIRTHDATE <b>April 30, 1914</b>		9. AGE (In years lost birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State or foreign country) <b>Mobile, Alabama</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>William Greene</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)			16. SOCIAL SECURITY NO 17. INFORMANT <b>Charles Driver, Jr.</b> Address <b>1823 Bay St. S.E. Wash., D.C.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest. Possible myocardial Infarction</b>			19. INTERVAL BETWEEN ONSET AND DEATH		
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Prob. Acute Cholysistitis</b>			20. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Brandywine</b> (County) <b>Md.</b> (State) <b>Md.</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> , 1966, to <b>12/15</b> , 1966, that (I) (we) last saw the deceased alive on <b>12/15</b> , 1966, and that death occurred at <b>6 A.M.</b> from causes and on the date stated above.			22a. SIGNATURE <b>Edwin J. Jensen</b>		
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>			22d. ADDRESS <b>Prince Geo. General Hospital, Cheverly</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 19-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gibbons Church Cem. Brandywine, Md.</b>	
23d. LOCATION (City or Town) (County) <b>Md.</b>					
24. FUNERAL DIRECTOR <b>Marcell Adams Aquasco, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
VR A15 (4) 20 M 1/66				DATE	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

17611

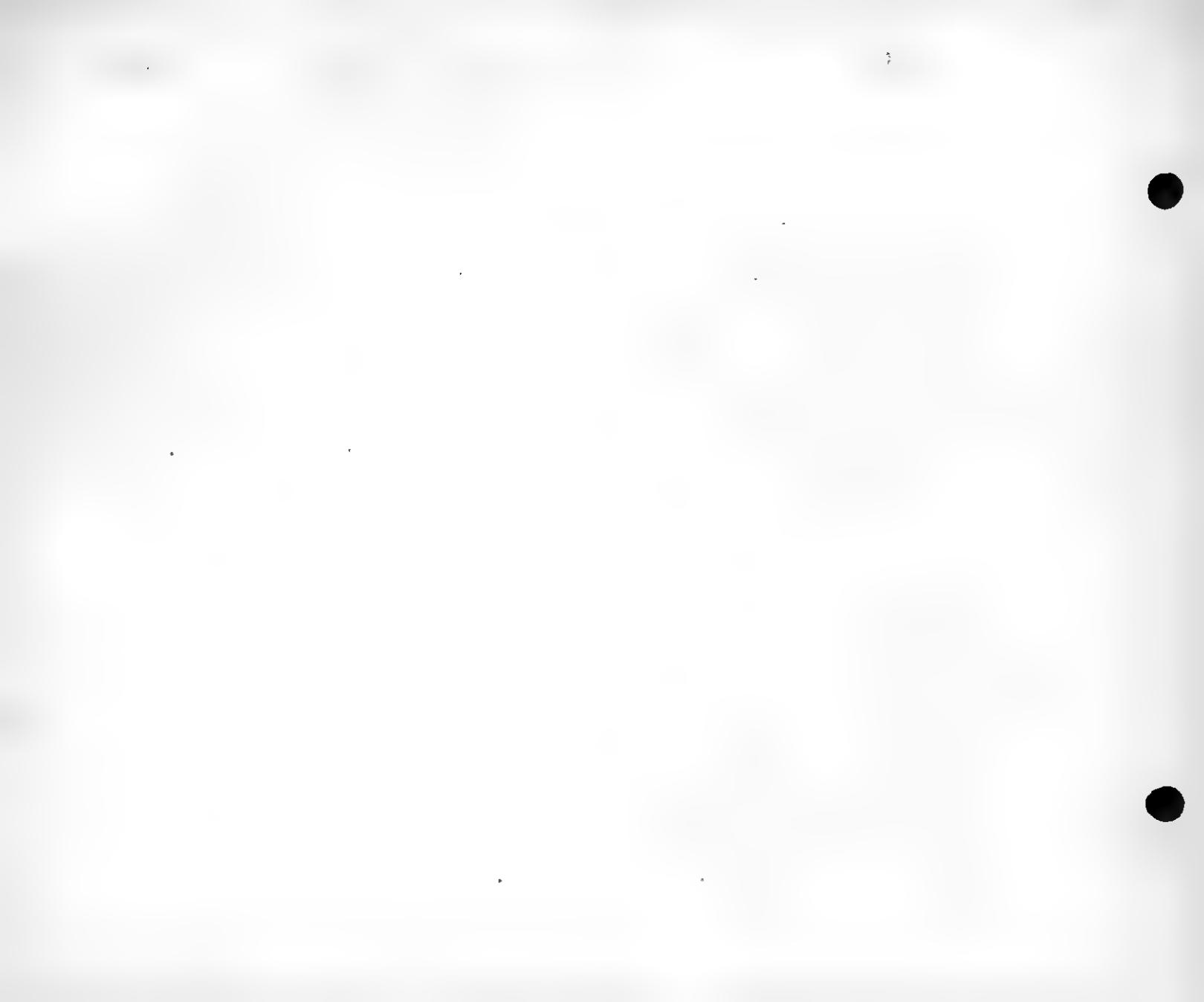
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17604

*31*  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

*2*  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2 USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN Tb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First <b>Dominic</b>	Middle <b></b>	Last <b>Falcone</b>
4 DATE OF DEATH <b>12</b>	Month <b>15</b>	Day <b>19</b>	Year <b>66</b>
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED W DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>9-9-1906</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jessie Falcone</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Di Rocco</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>578 09 2260</b>	
17. INFORMANT <b>Emma M Falcone Hyattsville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema, bilateral - severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>491X</b> (b) <b>Bronchopneumonia, early, bilateral</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f (City or town) <b></b>		(County) <b></b> (State) <b></b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Colmar Manor Pro Geo Md.</b>	
22. DATE SIGNED <b>12-16-66</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Dec 19, 1966</b>	23c NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>
23d LOCATION (City or Town) <b>Colmar Manor Pro Geo Md.</b>		(County) <b></b> (State) <b></b>	
24 FUNERAL DIRECTOR <b>E. Gasch's Sons Hyattsville, Md.</b>		ADDRESS	25a REC'D BY REGISTRAR DATE <b>DEC 22 1966</b>
			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17612

## CERTIFICATE OF DEATH

17605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince Georges</b>	
c. LENGTH OF STAY IN b <b>35 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>5408 39th Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	FIRST <b>William</b>	MIDDLE <b>T</b>	LAST <b>Fall</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>15 Dec., 1882</b>
8. AGE (In years last birthday) <b>84 yrs.</b>	9. IF UNDER 1 YEAR Months <b>0</b> Dofs <b>0</b> Hours <b>0</b> Min <b>0</b>	10. IF UNDER 24 HRS Months <b>0</b> Dofs <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Photographer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Fall</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577 05 8290A1</b>	
17. INFORMANT <b>M Helen K Fall</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>610X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>	
DUE TO (b) <b>Phlebitis and sis. b. lat</b> DUE TO (c) <b>Prosthetic Hypertrophy, Surgery - Arteria</b>		12/6/66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Colmar Manor Pro Geo</b>
20f. (City or town) <b>Hyattsville</b>		(County) <b>Md.</b>	
(State) <b>MD.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1, 1957</b> to <b>12/14, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/14, 1966</b> , and that death occurred at <b>4:00 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>Charles Judge</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon Kelley, M.D.</b>		22d. ADDRESS <b>6124 16th St., Hyattsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 17, 1966</b>	23c. NAME OF CEMETERY OR Crematory <b>Ft Lincoln Cemetery</b>
23d. LOCATION (City or Town) <b>Colmar Manor Pro Geo</b>		(County) <b>Md.</b>	
(State) <b>MD.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17613

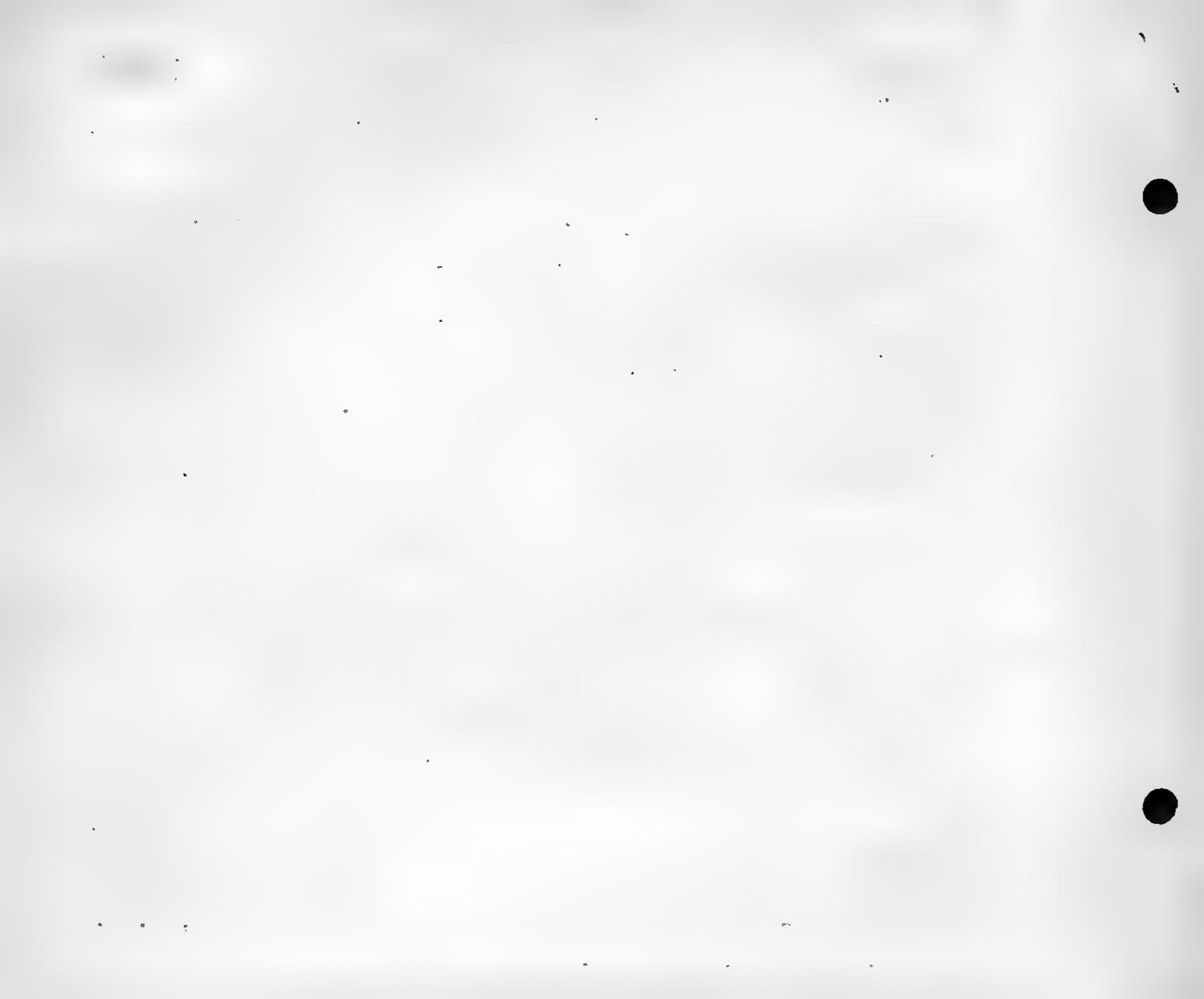
CERTIFICATE OF DEATH

17606

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>		c. LENGTH OF STAY IN IB <b>25 mos.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>		d. STREET ADDRESS <b>3720 Alton Place, N. W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PAINT BRANCH NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First <b>G-GEORGE</b>	Middle <b>PETER</b>	Last <b>FIELDS</b>
4. DATE OF DEATH Month <b>DEC</b>	Month <b>23</b>	Day <b>19</b>	Year <b>66</b>
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>1-12-1895</b>
9 AGE (In years lost birthday) <b>71 yrs</b>	10 IF UNDER 1 YEAR Months <b>3M</b>	11 IF UNDER 24 HRS Days <b>12 CITIZEN OF WHAT COUNTRY?</b> <b>MONTGOMERY CO MARYLAND U.S.A.</b>	Hours <b>3 hrs</b>
100 USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>DRAFTSMAN</b>	10b KIND OF BUSINESS OR INDUSTRY <b>DRAFTSMAN</b>	11 BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY CO MARYLAND U.S.A.</b>	
13 FATHER'S NAME <b>WM. FIELDS</b>	14 MOTHER'S MAIDEN NAME <b>Marian V. Rabbitt</b>	Address <b>577-34-1513 IN CHARTER NURSING Home</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>YES WW I</b>	16 SOCIAL SECURITY NO <b>577-34-1513</b>	17 INFORMANT <b>IN CHARTER NURSING Home</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Measles/mic Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>15 yrs -</b>			
DUE TO (c) <b>Cirrhosis</b> <b>1 yr -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that <b>I</b> (this hospital) attended the deceased from <b>10-14, 1966</b> to <b>12-23, 1966</b> , that <b>I</b> (we) last saw the deceased alive on <b>12-23, 1966</b> , and that death occurred at <b>8:30 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>12-24-66</b>	
22a SIGNATURE <b>R D Bauer MD</b>		22d. ADDRESS <b>2513 Buckedge Rd. Bethesda, MD</b>	
22c. PHYSICIAN'S NAME (Type) <b>R D Bauer MD</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>12-27-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>DECEMBER 27, 1966</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

17607

**10. HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>P.G.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>		c. LENGTH OF STAY IN 16 <i>9 mo -</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Magnolia Gardens Nursing Home</i>		d. STREET ADDRESS <i>4104 Ogallalope St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Jane</i>	Middle <i>W</i>	Last <i>FLETCHER</i>	14. DATE OF DEATH <i>12-17-66</i>	Month <i>Dec</i>	Day <i>17</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12-28-1878</i>	9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas H. Walker</i>		14. MOTHER'S MAIDEN NAME <i>Mary e. Hughes</i>		15. INFORMANT <i>John M. Fletcher</i>		Address <i>3823 Bangor St. B.C. Washington D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>		20. DUE TO (b) <i>Coronary Arteriosclerosis</i>		21. DUE TO (c)	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>26 March, 1966, to 17 Dec., 1966</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>26 March, 1966, to 17 Dec., 1966</i> , that (I) (we) last saw the deceased alive on <i>16 Dec., 1966</i> , and that death occurred at <i>24 M.</i> from causes and on the date stated above.							
22a. SIGNATURE <i>Wm. d. Dematt</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>17 Dec. 1966</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL (CREMATION) REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Dec. 17, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>St. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Clemar Manor, P.G. Md.</i>	
24. FUNERAL DIRECTOR <i>Francis Masch Sons</i>		ADDRESS <i>Hopkiss, Md.</i>		25a. REC'D BY REGISTRAR <i>REC'D 2 DEC 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17615

## CERTIFICATE OF DEATH

17609

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			b. COUNTY <b>Suitland</b>		
c LENGTH OF STAY IN TB <b>4 days</b>			c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>16.1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>4702 Davis Avenue</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <b>William L. Fox</b>			4. DATE OF DEATH Month <b>December 15</b>	Day <b>1966</b>	Year
S SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/29/89</b>	9 AGE (in years last birthday) <b>77 yrs.</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11 BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>			12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Adam Fox</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Winks</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Anna Marie Bare (Dau.) Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Severe Coronary arteriosclerotic Heart Disease</b>					
DUE TO (c) <b>Fracture Right knee and (A) lungs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>A.M.</b>				(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> , 19 <b>66</b> , to <b>12/15</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>12/15</b> 19 <b>66</b> , and that death occurred at <b>10:25 M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>A.C. funeral -</b>					
22b. DATE SIGNED <b>Dec. 15-1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>H. E. Agnew, M.D.</b>		22d. ADDRESS <b>Pr. Geo's. Gen. Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 19-1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>New Hope Cemetery</b>	
23d. LOCATION (City or Town) <b>Summers County, West Va.</b>				(County) (State)	
24. FUNERAL DIRECTOR <b>Simmons Bros. 1661- Gd. Hope Road SE. Wash, DC</b>		ADDRESS <b>simmons bros inc.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17516

CERTIFICATE OF DEATH

17616

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

<b>1 PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)</b>			
a. COUNTY <b>Prince George's</b> MARYLAND				b. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>36 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>621 Sheridan St.</b>			
3. NAME OF DECEASED First <b>Samuel</b> Middle <b>Frichter</b> Last				4. DATE OF DEATH Month <b>December</b> Day <b>2, 1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/2/1902</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Max Frichter</b>				14. MOTHER'S MAIDEN NAME <b>Anna Dyner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-03-9586</b>		17. INFORMANT <b>Cecelia Ginsberg</b> Address <b>4711 N. 11th St. Philadelphia, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b> DUE TO <b>Subphrenic Abscess</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Septic Thromboembolism</b> DUE TO <b>Septic Thromboembolism</b> <b>2 weeks</b>							
(c) <b>Psychotic Disorder With Hallucinations</b> <b>3 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary Atherosclerosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 27, 1966</b> , to <b>Dec. 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 2, 1966</b> , and that death occurred at <b>1:20 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Saul Schwartzback</b>				22b. DATE SIGNED <b>12/2/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Saul Schwartzback</b>				22d. ADDRESS <b>1726 Eye St. Wash., D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-5-66</b>		23c. NAME OF CEMETERY OR CREMATORIALY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cottage City Md.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>				ADDRESS <b>4217 9th St. Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE <b>DEC 7 1966</b>			



FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in part I, item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17611

1. PLACE OF DEATH a. COUNTY  Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital	d. STREET ADDRESS 4115 71st Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)  Harvey Galen Galentine	First Middle Last	4. DATE OF DEATH 12 11 19 66	Month Day Year		
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Oct., 1919	9. AGE (In years last birthday) 47 yrs	F. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Greensburg Pa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Homer F Galentine		14. MOTHER'S MAIDEN NAME Estella N Wible		Address Landover Hills, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 578 12 1301		17. INFORMANT Joyleen E Galentine	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Heart failure		INTERVAL BETWEEN ONSET AND DEATH minutes	
Arteriosclerotic heart disease				over 1 yr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJRY Month, Day, Year Hour a.m. p.m. 19		20d. INJRY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 14, 1966	23c. NAME OF CEMETERY OR CEMATORIUM Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Virginia	22. DATE SIGNED 12-11-66
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE DEC 16 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17S18

CERTIFICATE OF DEATH

17612

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale Md</b>		c. LENGTH OF STAY IN 1b <b>one day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>	
d. STREET ADDRESS <b>115. Northway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EVA C. GARNER</b>		4. DATE OF DEATH Month Day Year <b>December 15th 1966</b>	
S SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>8.10.1887</b>		9. AGE (In years last birthday) <b>79 yrs</b>	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rock</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Winstead</b>	
14. MOTHER'S MAIDEN NAME <b>Hospital Records</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>170X</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Address</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cancer of breast &amp; metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9y</b>	
DUE TO (b) <b>to bones</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Calio Virginia</b>
20f. (City or town) <b>Calio</b>		(County) <b>Virginia</b>	
(State) <b>Virginia</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 14th 1966</b> to <b>Dec 15 1966</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 1966</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>Dec. 15th 1966</b>	
22a. SIGNATURE <b>J. H. Beyleman</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b></b>		22d. ADDRESS <b></b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12.17.66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethany Baptist Cem</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home. 300.4th st N E</b>		ADDRESS	25a. RECEIVED BY REGISTRAR <b>DEC 19 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17619

## CERTIFICATE OF DEATH

17613

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, tremotion, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4401 Queensbury Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Guy Middle H.		Last Gerald		4. DATE OF DEATH December 1, 1966		Month Day Year	
S SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-79	9. AGE (in years 87 lost birthday) yrs	10. UNDER 1 YEAR Months	11. UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (County & State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Iver Sven Gerald		14. MOTHER'S MAIDEN NAME Marcella Strom					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 217 44 6865		17. INFORMANT Medical Record/Pt.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		b. CONGESTIVE HEART FAILURE. General arterioclerosis and thrombosis		c. INTERVAL BETWEEN ONSET AND DEATH 8 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 18</u> , 1966 to <u>DEC 1</u> , 1966, that (I) (we) last saw the deceased alive on <u>OCT 1</u> , 1966, and that death occurred at <u>RIVERDALE</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>L W Malin</u>		22b. DATE SIGNED 12-1-66					
22c. PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>		22d. ADDRESS Riverdale Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec 5, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D. BY REGISTRAR DEC 7 1966		25b. REGISTRAR'S SIGNATURE <u>James Jones</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17620

## CERTIFICATE OF DEATH

17614

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

\*\* SEE REVERSE SIDE

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL		b. COUNTY PRINCE GEORGE'S	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5702 ALICE AVENUE		d. STREET ADDRESS 5702 ALICE AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First THEODORE	Middle DAVID	Last GIBBS
4. DATE OF DEATH	Month DECEMBER	Day 21	Year 1966
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1 APR 1927	9. AGE (In years last birthday) 39 yrs	F UNDER 1 YEAR Months Days	I IF UNDER 24 HRS Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARMAN - MSGT	10b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE	11. BIRTHPLACE (County & State or foreign country) FOUNTAIN, TENN	
13. FATHER'S NAME WILLIAM DEWEY GIBBS (DECEASED)	14. MOTHER'S MAIDEN NAME ROSA COREALIA DAVIS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) YES	16. SOCIAL SECURITY NO 1950-PRESENT	17. INFORMANT JACQUELINE GIBBS-WIFE-SAME AS #2	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE			
IMMEDIATE INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to 21 December 1966, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 6:30 PM, from causes and on the date stated above.			
22a. SIGNATURE Richard J. Wiseley		22b. DATE SIGNED 21 DEC 1966	
22c. PHYSICIAN'S NAME (Type) RICHARD J. WISELEY, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 12/27/66	23b. DATE THEREOF 12/27/66	23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON N.A.T.L.	23d. LOCATION (City or Town) ARLINGTON VA. (County) (State)
24. FUNERAL DIRECTOR W.W.CHAMBERS CO. INC.	ADDRESS 517 1/2 ST. S.E. WASH. D.C.	25a. REC'D BY REGISTRAR ULU 26 1966	25b. REGISTRAR'S SIGNATURE John J. Chamb

ITEM #21 CONTINUED:

MSGT THEODORE D. GIBBS, WAS BROUGHT INTO THE EMERGENCY ROOM, USAF HOSPITAL ANDREWS, ANDREWS AFB, WASHINGTON D.C. 20331, AT 6:10 P.M. HOURS, 21 DEC 1966, BY THE OXON HILL RESCUE SQUADRON AND WAS PRONOUNCED DEAD ON ARRIVAL. DR JOHN KEHOE, PRINCE GEORGE'S COUNTY MEDICAL EXAMINER WAS CONTACTED AND HE GAVE PERMISSION TO THE USAF HOSPITAL ANDREWS TO PERFORM THE AUTOPSY AND TO PREPARE THE DEATH CERTIFICATE.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17S23

## CERTIFICATE OF DEATH

17617

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6102 Lombard St	
3. NAME OF DECEASED (Type or print) First Anna Middle E. Gurney		4. DATE OF DEATH Month December Day 22, Year 66.	
S SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH April 13, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11 BIRTHPLACE (County & State, or foreign country) Michigan
13. FATHER'S NAME Marvin Pickett		14. MOTHER'S MAIDEN NAME Lettie Foster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	17. INFORMANT Address Margaret Gurney Cheverly, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Cachexia</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cancerous of Breast &amp; metastas</i> (c) <i>To Lung - Liver - Relg. Bone marrow</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>4-1-</u> , 19 <u>40</u> , to <u>12-22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-22</u> 19 <u>66</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>A Deitz</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Dec 22, 1966
22c. PHYSICIAN'S NAME (Type) At Deitz		22d. ADDRESS Pro Geo Plaza Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec 27, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Crematory
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D. BY REGISTRAR DATE DEC 27 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles J. Ogle</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17S22

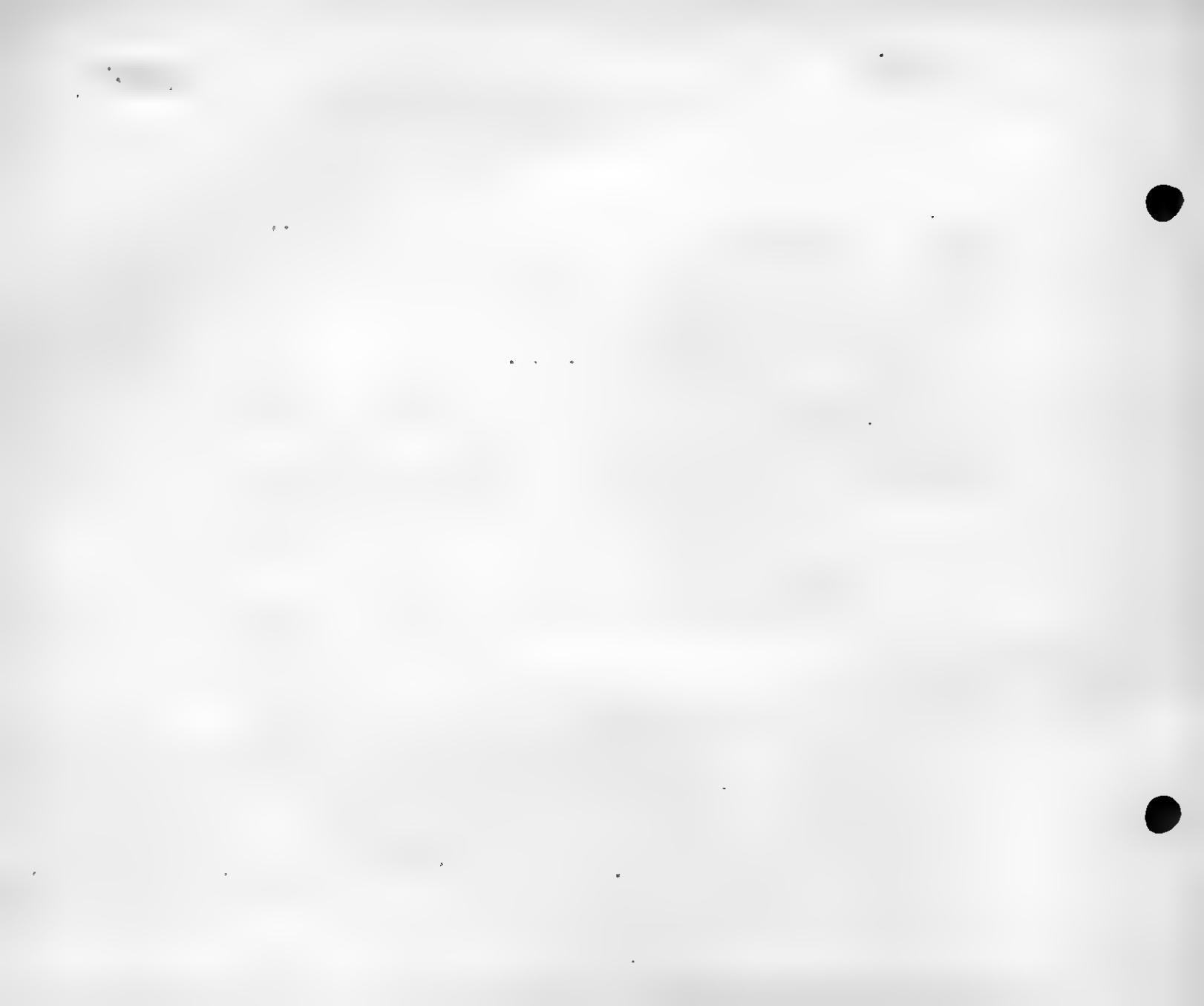
## CERTIFICATE OF DEATH

17616

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland			b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital						d. STREET ADDRESS 5313 76th. Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Gertrude			First	Middle	Lost	4. DATE OF DEATH 12	Month	Doy	Year	14	19 66
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-16	9. AGE (In years last birthday) 50 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) Bank clerk			10b. KIND OF BUSINESS OR INDUSTRY Wash. D.C. National Bank of			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles A. Gude						14. MOTHER'S MAIDEN NAME Gertrude Chapman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Unknown			16. SOCIAL SECURITY NO 577 07 0263			17. INFORMANT Patient upon admission			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			massive pleural effusion + pneumoperitoneum						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			Metastatic Ca to lung +								
DUE TO (c)			Carcinoma rt breast						1 yr		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 12-5-66, 1966, to 12-14, 1966, that (I) (we) last saw the deceased alive on 12-14-66 1966, and that death occurred at 6:10AM, from causes and on the date stated above.			22b. DATE SIGNED 12-14-66								
22o. SIGNATURE R. F. Wilkinson, M.D.			22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.								
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec 16-1966	23c. NAME OF CEMETERY OR CREMATORIUM St Lincoln Cemetery			23d. LOCATION (City or Town) Colmar Manor Pky Sec Md				
24. FUNERAL DIRECTOR F. Gooch & Sons Hyattsville, Md			1 ADDRESS			25a. REC'D BY REGISTRAR DEC 19 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20 M 1/66						DATE					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17621

## CERTIFICATE OF DEATH

17615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate lim.ts, write RURAL and give nearest town) <b>Riverdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>6833 Riverdale Rd., Apt. A-2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>Ray</b>	Middle <b>M.</b>	Last <b>Guckert</b>
S SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4/23/14</b>
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Marlow</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>167 093 150</b>	
17. INFORMANT <b>Isabel E. Guckert</b>		Address: <b>6833 Riverdale Rd Riverdale, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade (600 cc)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Bronchogenic carcinoma (① fibrum</b> DUE TO (c) <b>Pulmonary emboli LLL.</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1966</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1966</b> , to <b>Dec 5, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 5, 1966</b> and that death occurred at <b>3:25 P.M.</b> from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <b>Samuel J.N. Sugar</b>		22b. DATE SIGNED <b>12/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel J.N. Sugar, M.D.</b>		22d. ADDRESS <b>4637 Eastern Ave., Washington 18, D. C.</b>	
23a. BURIAL/CREMATION REMOVAL(SPECIFY) <b>Cremation</b>		23b. DATE THEREOF <b>12-9-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>DEC 9 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

Items 10, 11, 12, 13, 14 Film G384 1-166 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17618

FOR STATE  
HEALTH DEPT

17624

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 TO BE RETAINED FOR YOUR FILES.

1. PLACE OF DEATH a. COUNTY  Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George		
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN Tb 5 hrs.	c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Suitland	d. STREET ADDRESS 5001 Holly Spring Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Arthur		First Hall	Middle Month Day Year 12 10 19 66	
4. SEX M	5. COLOR OR RACE W	6. MARRIED WIDOWED	7. NEVER MARRIED DIVORCED	
8. DATE OF BIRTH 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (In years last birthday) 51 yrs.		
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Wash., D. C.		
13. FATHER'S NAME George Hall		14. MOTHER'S MAIDEN NAME Minnie		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT		Address		
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) <u>Multiple skull fractures</u> DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 5 1/2 Hrs.				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:00 am 12 10 19 66		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car involved in collision		
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Penna Ave at 61st Place, Bradbury Heights		(City or town) P.G. (County) Md. (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.,		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	22. DATE SIGNED 12-11-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 12/15/66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat.	23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR Kellins Funeral Home Inc. Trust Dept.		ADDRESS 4339	25a. REC'D BY REGISTRAR DEC 19 1966 DATE	25b. REGISTRAR'S SIGNATURE Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17625

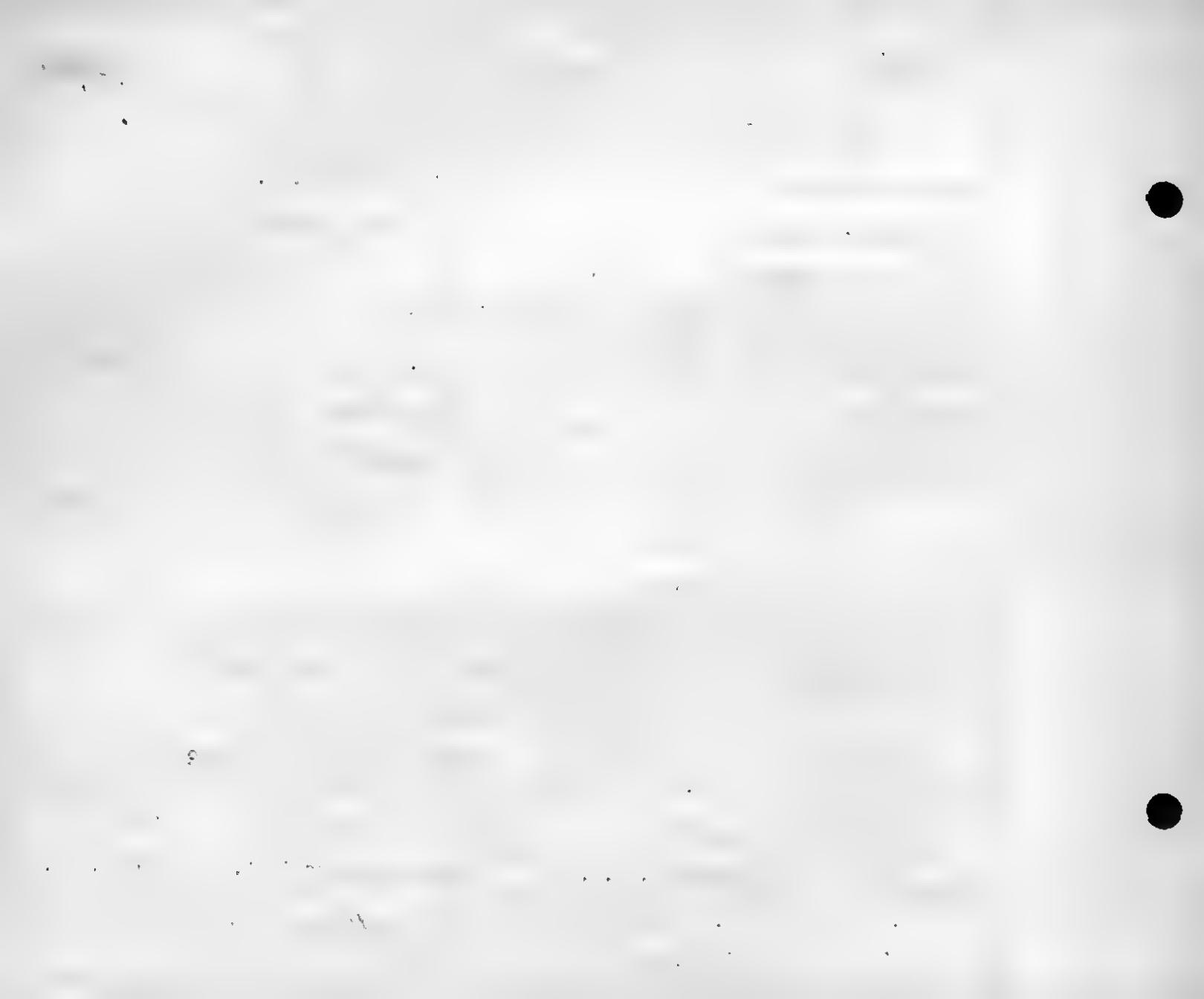
## CERTIFICATE OF DEATH

17619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Dale Hospital</b>		c. LENGTH OF STAY IN lb <b>2½ months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glen Dale Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
		d. STREET ADDRESS <b>no fixed address</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Bertha</b>	Middle <b>R.</b>	Last <b>Hall</b>
4. DATE OF DEATH <b>12/10/66</b>	Month Year Day	Month Year 19	Day Year
S. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6/2/1895</b>	9. AGE (In years last birthday) <b>71 yrs</b>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Ga.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>George Hall</b>	14. MOTHER'S MAIDEN NAME <b>Sallie Gear</b>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO <b>-</b>	17. INFORMANT <b>decedent</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebellar infarction</b> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Cerebral arteriosclerosis</b> lost. DUE TO (b) <b>Chronic endocarditis of aortic valve</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic endocarditis of aortic valve</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/28/66</b> , to <b>12/10/66</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>12/10/66</b> , and that death occurred at <b>3:10PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED <b>12/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>HARMONY</b>		23d. LOCATION (City or Town) (County) (State) <b>HIGHLAND PARK, MD.</b>	
24. FUNERAL DIRECTOR <b>ROLLINS INC.</b>		25a. ADDRESS <b>4339 Hunt Pl. N.E.</b>	
		25b. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

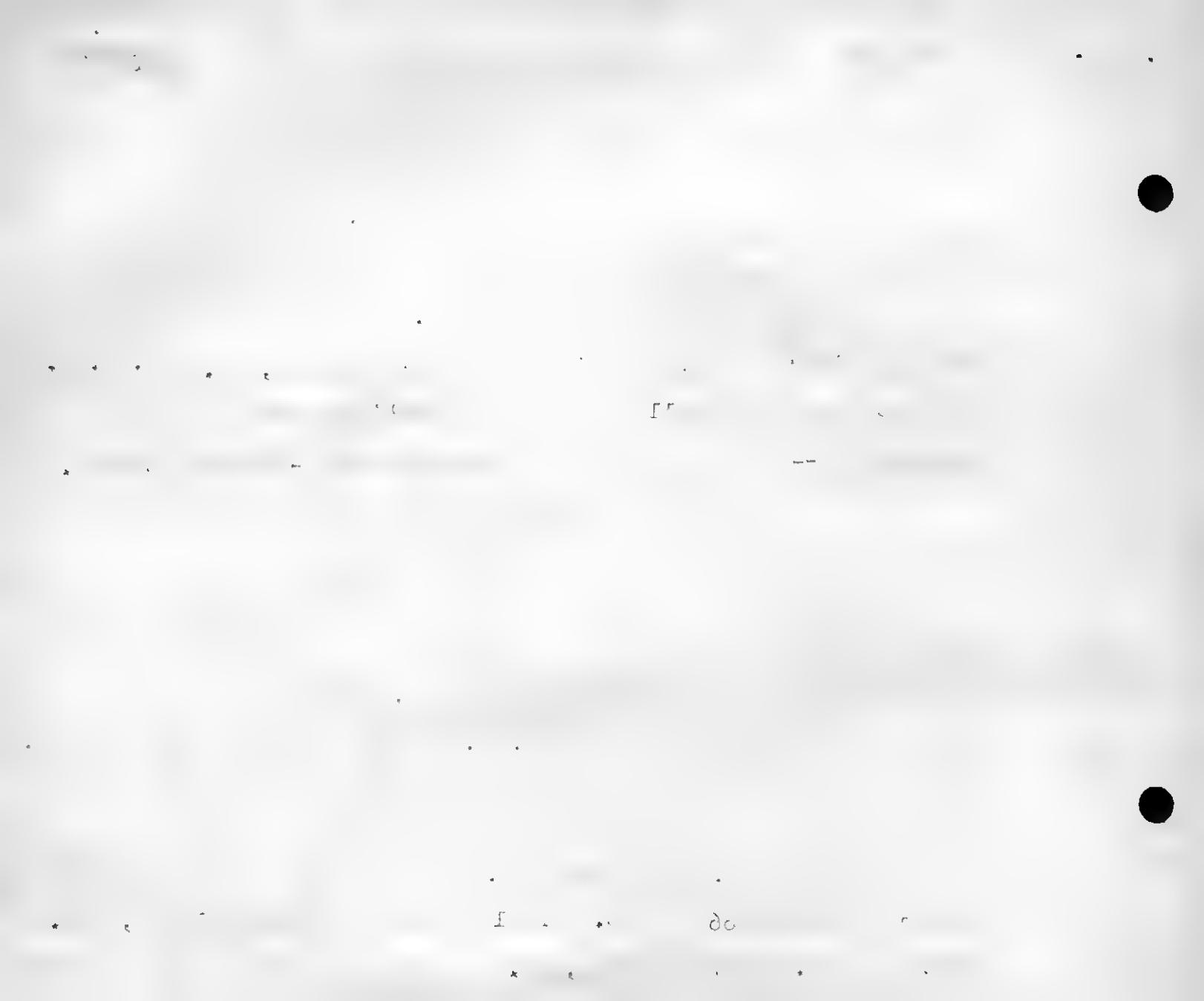
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

To DUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17626		MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17620	
1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>								
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>DOA</b>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		d. STREET ADDRESS <b>3841 Church Street</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>					d. STREET ADDRESS <b>3841 Church Street</b>					e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Hamilton</b>		First	Middle	Last	4 DATE OF DEATH <b>12 19 1966</b>		Month	Day	Year	13 FATHER'S NAME <b>Hamilton Alexander Hall</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Dec. 1900</b>		9 AGE (In years as of birthday) <b>66 yrs.</b>	10. BIRTHPLACE (State or foreign country) <b>Upper Marlboro, Md.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
10a. US JAIL OCCUPATION (Give kind of work done during most of working life, even if ret'd) <b>Horse Trainer</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. MOTHER'S MAIDEN NAME <b>Eleanor Sweeney</b>					14. INFORMANT <b>Marguerite Hall-Same as Item #2.</b>					Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>					16. SOCIAL SECURITY NO <b>--</b>					17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO <b>Laceration of neck</b> <i>Sixty</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH								
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b) <b>Pedestrian struck by car.</b>											
20c. TIME OF INJURY Month, Day, Year Hour or m <b>3:15pm 12-19-1966</b>		20d. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>St. Rt. 4, 1/4 mile west of Upper Marlboro, Md.</b>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>St. Rt. 4, 1/4 mile west of Upper Marlboro, Md.</b>		20f. (City or town) <b>Upper Marlboro, Md.</b>		(County) <b>Md.</b>		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED <b>12-20-66</b>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.											
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county) <b>Riverdale, Md.</b>										23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>12/22/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Carmel Cemetery</b>								23d. LOCATION (City or Town) <b>Upper Marlboro, Md.</b>			
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		ADDRESS								25a. REC'D BY REGISTRAR <b>JAN 6 1967</b>			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>										DATE			



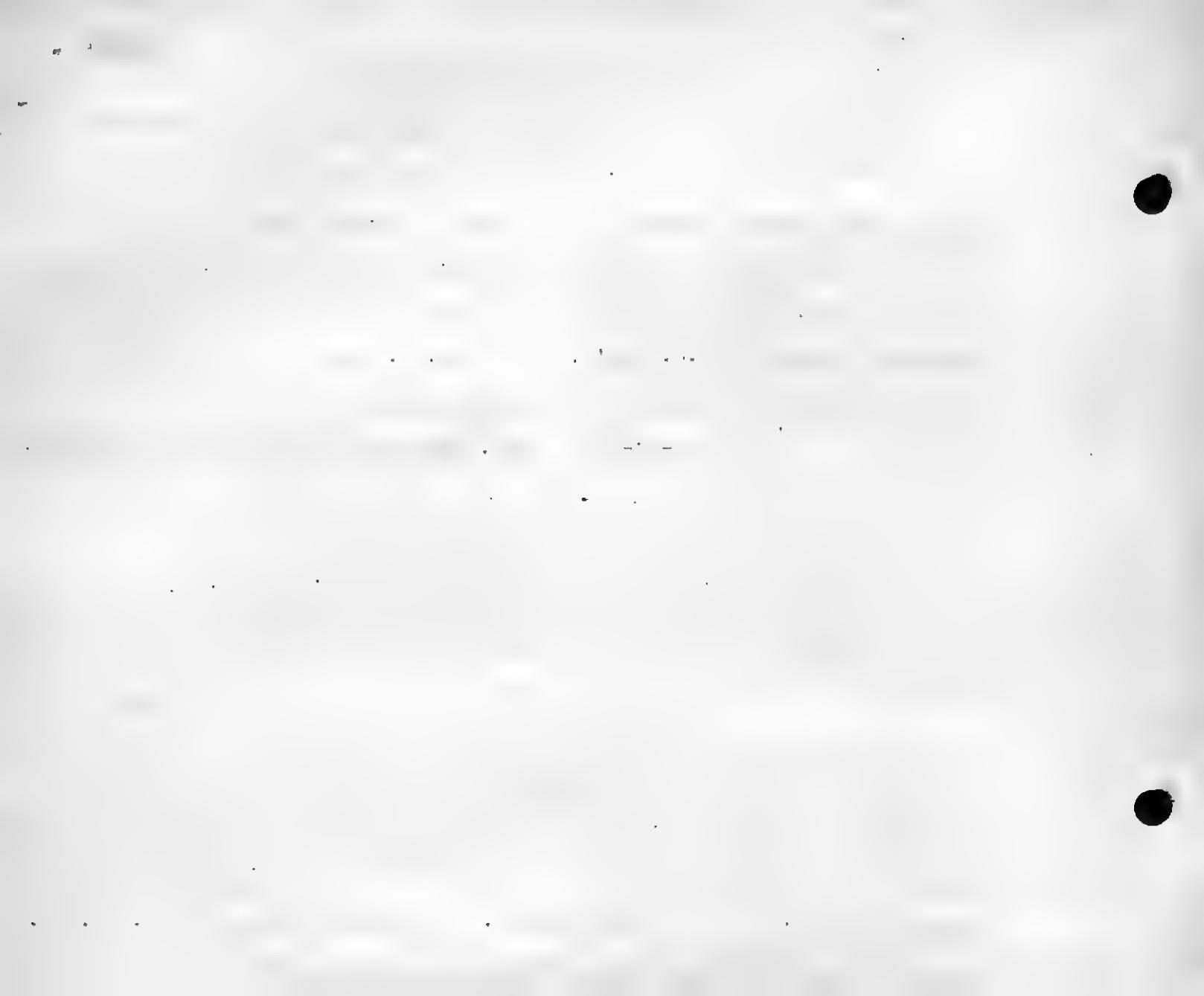
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**PAGE 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

1 17827		1 17827	
1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b 1 mo. 2 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rose Haven	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Dover Ave. c/o North Beach P.O.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Scott Last Hall		4. DATE OF DEATH Dec. 11, 1966	
5. SEX Male		6. COLOR OR RACE Cauc.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-06	
WIOOWEO <input type="checkbox"/>		9. AGE (In years last birthday) 60 yrs.	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Property Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Salem, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Scott Hall		14. MOTHER'S MAIDEN NAME Mary Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-44-9746	
17. INFORMANT Mrs. Mary Hall,		Address Rose Haven, North Beach, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rt. Bronchogenic Cancer</i> 162.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Collapsed left lung</i> DUE TO (c) <i>Bilateral severe bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 20, 1966</i> , to <i>Dec. 4, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 4, 1966</i> , and that death occurred <i>Dec. 4, 1966</i> M, from the causes and on the date stated above.		22b. DATE SIGNED <i>Dec. 4, 1966</i>	
22c. SIGNATURE <i>Charles C. Hageage</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>3308 Perry St., Mt. Rainier, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Friendship Chr. Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Friendship, A. A. Co., Md.</i>	
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home (Owings, Md.)</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE DEC 8 1966			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17622

TO DEPUTY EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>Cheverly DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>7120 Lory Drive</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John Aloysius Hallisey</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>12 74 19 66</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>31 August 1897</b>	9. AGE (In years, months, days, etc.) lost birthday <b>69 yrs</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>D D S Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Georgetown University</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
13. FATHER'S NAME <b>John M Hallisey</b>			14. MOTHER'S MAIDEN NAME <b>Ellen Lynch</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>578 44 1261</b>		17. INFORMANT <b>Helen C Hallisey</b> Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>And Myocardial fibrosis</b> DUE TO Coronary arteriosclerotic heart disease (c) <b>over 5 yrs.</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>over 5 yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus - over 5 years</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>While at work</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>12-15-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 17, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Pro Geo Md</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR ATSMV 6M 1/66					



**1**  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												17623			
CERTIFICATE OF DEATH												17623			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY <u>PRINCE GEORGES</u>				a. STATE <u>MARYLAND</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST HYATTSVILLE</u>				b. COUNTY <u>PRINCE GEORGES</u>											
c. LENGTH OF STAY IN ID <u>1 1/2 YRS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr. HYATTSVILLE</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1904 POURHATAN Road.</u>				d. STREET ADDRESS <u>1904 POURHATAN Road.</u>											
e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> X															
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
<u>JOHNSIE</u>			<u>EVELYN</u>	<u>HAMPTON</u>		<u>DEC</u>		<u>14</u>	<u>1966</u>						
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS				
<u>F</u>		<u>W</u>		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<u>4-8-21</u>		<u>46</u> yrs.		Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>1ST NATIONAL BANK</u>				11. BIRTHPLACE (County & State, or foreign country) <u>ALEXANDRIA VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOHN L. LOVE</u>				14. MOTHER'S MAIDEN NAME <u>MOLLIE SUE WELLS</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-42-2960</u>				Address <u>1904 POURHATAN Rd</u>							
17. WAS INFORMANT <u>EVELYN WILLIAMS</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <td colspan="4">INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR.</u></td> <td colspan="4"></td>				INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>ARTERIOSCLEROTIC HEART DISEASE</u>				DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTHYROIDISM</u>												19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19															
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 15, 1965</u> , to <u>DEC 14, 1966</u> , that (II) <u>never</u> last saw the deceased alive on <u>DEC 14, 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Samuel J.N. Sugar</u>				22b. DATE SIGNED <u>DEC 14, 1966</u>											
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL J.N. SUGAR</u>				22d. ADDRESS <u>4637 EASTERN AVE WASHINGTON DC</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>DEC. 17 1966</u>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>UNION CEMETERY</u>		23d. LOCATION (City, town or county) <u>ALEXANDRIA VA.</u>		(State)					
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. RIVERDALE, MD.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>								25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>DEC 19 1966</u>											



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17630

## CERTIFICATE OF DEATH

17624

**HOSPITAL** \_\_\_\_\_  
**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full, it should be detached or used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md.</i>		b. COUNTY <i>Prince Georges</i>	
c. LENGTH OF STAY IN 1b <i>2 yrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville - Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>2114 Chapman Road</i>		d. STREET ADDRESS <i>2114 Chapman Road -</i>	
3. NAME OF DECEASED (Type or print) CHARLES		e. DATE OF DEATH Month Day Year <i>Dec 12 - 18 1966</i>	
f. First MIDDLE <i>F.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE   WHITE		h. DATE OF BIRTH Month Day Year <i>6-12-92</i>	
i. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		j. AGE (In years from birth date) IF UNDER 1 YEAR, MONTHS <i>74 yrs.</i>	
k. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		l. 11. BIRTHPLACE (County & State, or foreign country) <i>West Virginia</i>	
m. 13. FATHER'S NAME <i>Dave Handschumacher</i>		n. 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
o. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or dates of service. <i>yes W W I</i>		p. 16. SOCIAL SECURITY NO. 17. INFORMANT <i>Mrs Ann M. Handschumacher (same as #2)</i>	
q. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } (b) DUE TO } (c) CORONARY ARTERIOSCLEROSIS		r. 19. INTERVAL BETWEEN ONSET AND DEATH <i>15 MIN.</i>	
s. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR, CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Hour a.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
p.m.		White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	
21. I certify that (i) (this hospital) attended the deceased from 1956, 19, to 12/18, 1966, that (i) (was) last saw the deceased alive on 12/18, 1966, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type) <i>R.C. KIRCHNER</i>		22b. DATE SIGNED <i>12/18/66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 21, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cemetery</i>		23d. LOCATION (City, town or county) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Bates, 254 Carroll St NW, DC</i>		25a. ADDRESS <i>648c-N H Ave - TAKOMA Park, Md.</i>	
25b. RECEIVED BY REGISTRAR <i>DEC 21 1966</i>		25c. REGISTRAR'S SIGNATURE <i>James Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 250, 251 Film 534 1/4/67 mh

17625

17631

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY <i>47</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN lb <b>9 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital, Glenn Dale, Md.</b>			d. STREET ADDRESS <b>610 Fairmont St., N. W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>James W. Handy</b>		First	Middle	Last	4. DATE OF DEATH <b>12 22 1966</b>	Month Day Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/31/01</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>579-16-3658</b>		17. INFORMANT <b>D. C. General Hospital</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recurrent cerebrovascular accident (thrombosis rt. vertebral artery)</b> DUE TO <i>332X</i>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Generalized arteriosclerosis</b>						unknown
DUE TO (b) <b>Cerebral arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>						unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/30/1966</b> to <b>12/22/1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/22/1966</b> , and that death occurred at 4:00 A.M. from causes and on the date stated above.						22b. DATE SIGNED <b>12/22/66</b>
22a. SIGNATURE <i>Moe Weiss</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>				
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>2029-6</b>		23b. DATE THEREOF <b>12-29-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Olivet</b>	23d. LOCATED ON (City or Town) <b>Washington</b> (County) <b>D.C.</b> (State)		
24. FUNERAL DIRECTOR <b>John R. Liskay</b>		ADDRESS <b>1432 York St. N.W.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>			25b. REGISTRAR'S SIGNATURE <i>John R. Liskay</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17S32

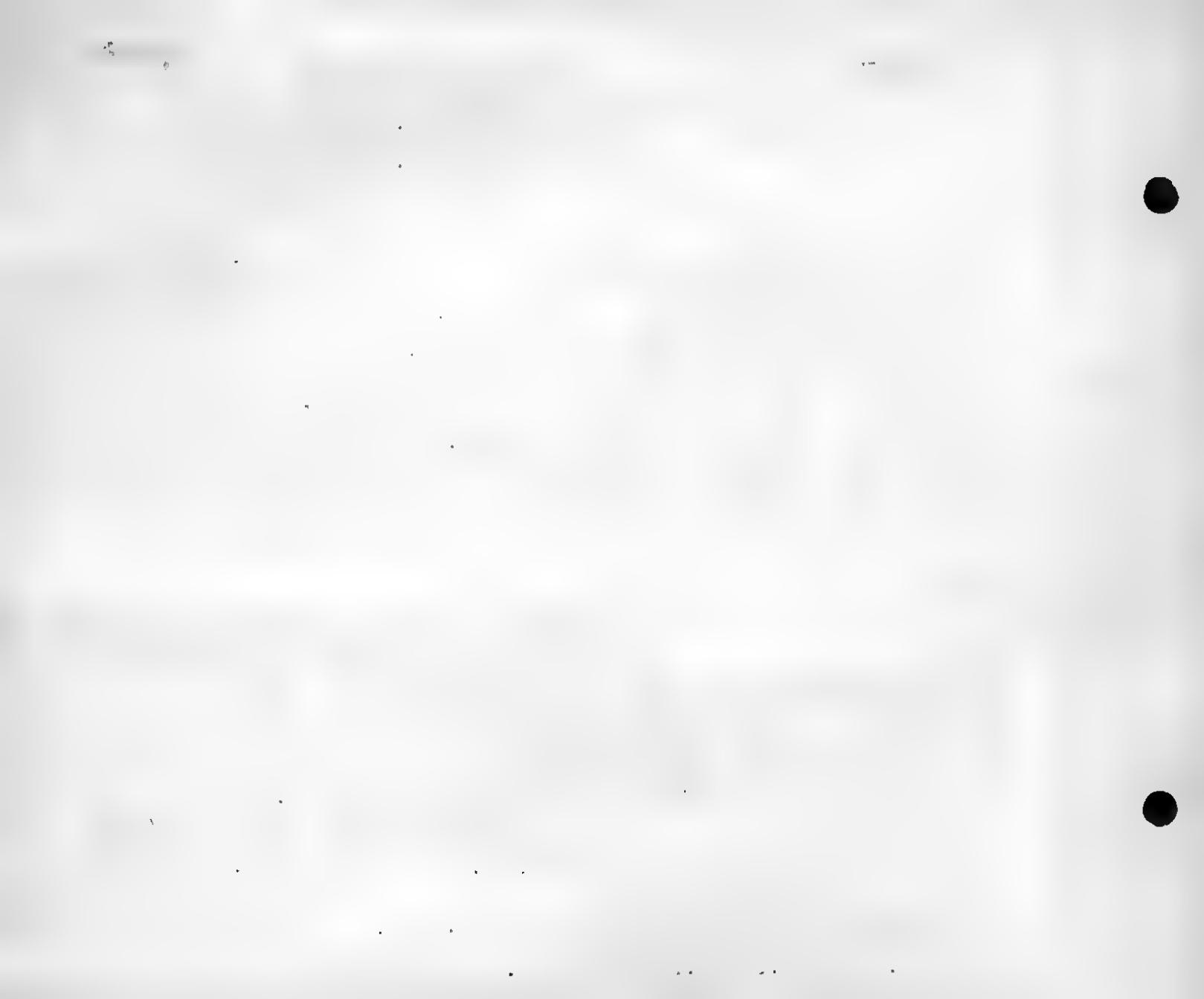
## CERTIFICATE OF DEATH

17626

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>Prince George's</b>			MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>			b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb <b>2 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>472 Kennebec Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>First Middle Baby Boy Hardee</b>			Lost			4. DATE OF DEATH <b>December 14 1966</b>			Month Day Year		
S SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/66</b>	9. AGE (In years lost birthday) yrs <b>2</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS Days <b>2</b>	Hours <b>0</b>	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Prince Georges, Maryland</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Hoyt Hardee</b>			14. MOTHER'S MAIDEN NAME <b>Jacqueline Clare Burnes</b>			Address <b>Same as above</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes g.v.e war or dates of service			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mother</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subdural hematoma</b> DUE TO <b>Bilateral Atrophy</b>									INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Tumor</b>			(b) DUE TO <b>Bilateral Atrophy</b>			(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12/12 1966</b> , to <b>12/14 1966</b> , that (I) (we) last saw the deceased alive on <b>12/14 1966</b> , and that death occurred at <b>9:45 A.M.</b> from causes and on the date stated above.											
22a. SIGNATURE <i>H. J. Bernardo</i>			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>12/17/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Bernardo</b>			22d. ADDRESS <b>Alvarado, M.D.</b>			23d. LOCATION (City or Town) (County) (State) <b>Riverdale, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12/24/66</b>		23c. NAME OF CEMETERY OR CREMATORIALy <b>Prince Georges Gen. Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly, PG, Maryland</b>					
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin., Cheverly, Md.</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



Item 2 Film 384 12-21-66 a MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17S33

## CERTIFICATE OF DEATH

17627

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a COUNTY PRINCE GEORGE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Md. b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md.		c LENGTH OF STAY IN lb 21 mos.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home 9104 Good Luck Rd - Maryland		e STREET ADDRESS Lanham	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED First MRS. BIRDIE Middle		4 DATE OF DEATH HARPER December 4 1966	
5 SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/8/1880	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Alexandria, Va.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Nolan		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records - Nursing Home		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 163X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Caronavirus of the Lung		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/2, 1966, to 2/4, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/4, 1966, and that death occurred at 7A M, from causes and on the date stated above.			
22a. SIGNATURE Jim Greco		22b. DATE SIGNED 12/9/66	
22c. PHYSICIAN'S NAME (Type) Wm R. GRECO M.D.		22d. ADDRESS Magnolia Gardens Nursing Home	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/1966	
23c. NAME OF CEMETERY OR CREMATORIUM Mount Comfort Cemetery		23d. LOCATION (City or Town) (County) (State) Fairfax County, Va.	
24. FUNERAL DIRECTOR Carroll Carter ADDRESS Alexandria, Va.		25a. REC'D BY REGISTRAR DATE DEC 8 1966	
The Demaine Funeral Homes, Inc. Va.		25b. REGISTRAR'S SIGNATURE Charles Judd	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

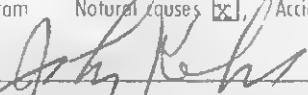
17634

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17628

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradbury Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5304 Pard Road</b>	
3. NAME OF DECEASED (Type or print) <b>Harry Shoemaker</b>		First <b>Harry</b>	Middle <b>Shoemaker</b>
4. DATE OF DEATH <b>12 18 1966</b>		5. lost	Month Year
6. SEX <b>Male</b>	7. COLOR OR RACE <b>White</b>	8. MARRIED WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/>
9. B. DATE OF BIRTH <b>3-22-1907</b>		10. AGE (In years lost birthday) <b>59 yrs</b>	11. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Special Police</b>	12. IF UNDER 24 HRS Hours Min
13. FATHER'S NAME <b>John Wesley Harrington</b>		14. MOTHER'S MAIDEN NAME <b>Nora E. Edwards</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO <b>1924-28 WWT 579-03-8582</b>	17. INFORMANT Address <b>Mary E.-wife Same as #2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>Pulmonary emphysema</b> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last <b>5271</b> (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH hours over 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) <b>(State)</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
22. DATE SIGNED <b>12-19-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-22-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington Natl. Cem.</b>		23d. LOCATION (City or Town) (County) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17535

CERTIFICATE OF DEATH

Item 12 Film 684 11/16/67

17629

1. PLACE OF DEATH  
a. COUNTY

Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

MARYLAND

c. LENGTH OF STAY IN 1b

2 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Hyattsville Nursing Home  
8500 Riggs Rd. Hyattsville, Md.

3. NAME OF  
DECEASED  
(Type or print)

First Middle Last

Harris Carrie E.

2. USUAL RESIDENCE (If deceased lived, if institution: Residence before admission)

a. STATE

D.C.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

1315 Iris St., N.W.

e. IS RESIDENCE  
ON A FARM?

YES  NO

5. SEX

F

6. COLOR OR RACE

Car.

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

12/14/1877

9. AGE (In years  
last birthday)

89 yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.

Dec. 27 1966

10a. USUAL OCCUPATION (Give kind of work done  
during working life, even if retired)

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Canada

12. CITIZEN OF WHAT  
COUNTRY?  
USA

13. FATHER'S NAME

William Harris

14. MOTHER'S MAIDEN NAME

Martha Mary Cunningham

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

086-26-2030

17. INFORMANT

Address

Hyattsville Nursing Home Records

INTERVAL BETWEEN  
ONSET AND DEATH

yr.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

A2CVD, with remote cerebral vascular accident

DUE TO

Conditions, If any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Senility, Blindness, spinal arthritis, chronic myopathy and polyuria

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m.

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)  
Dec. 27, 1966

21. I certify that (I) (this hospital) attended the deceased from Dec. 3, 1964, to Dec. 27, 1966, that (I) (we) last  
saw the deceased alive on Dec. 15, 1966, and that death occurred at 2:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Genevieve M.D. (John S.T. Kindle)

22b. DATE SIGNED  
Dec. 27, 1966

22c. PHYSICIAN'S  
NAME (Type)

Genevieve M.D.

22d. ADDRESS  
1106 Spring St  
Silver Spring, Md.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

Burial 29 Dec. 1966

23c. NAME OF CEMETERY OR Crematory

Forest Lawn Cemetery

23d. LOCATION (City, town or county) (State)

Buffalo N.Y.

24. FUNERAL DIRECTOR

Funeral Director

ADDRESS

No. Georgia Ave. N.W.

Washington D.C.

25a. REC'D. BY REGISTRAR

Dec. 26, 1966

Registrar's Signature  
Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for me as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17636 17630

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Bethesda</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>	c. LENGTH OF STAY IN 1B	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>University Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Leland Memorial</i>		d. STREET ADDRESS <i>4304 East W. Hawse</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Jerome</i>	First	Middle	Last <i>Frances Hartnett</i> 4. DATE OF DEATH <i>Dec 11</i> Month <i>Dec</i> Day <i>11</i> Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/11/02</i> 9. AGE (In years last birthday) <i>67 yrs.</i> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ELECTRITION</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph J.</i>	14. MOTHER'S Maiden NAME <i>MARGARET Graney</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY ND.	17. INFORMANT <i>LAWRENCE HARTNETT</i>	Address
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> INTERVAL BETWEEN ONSET AND DEATH 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Disease</i> (c) <i>Hypertensive Cardiovascular Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Previous myocardial infarction</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from , 1957, to Dec 11, 1966, that (I) (we) last saw the deceased alive on Oct 1966, and that death occurred at 7:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard L. Whelton</i>		22b. DATE SIGNED <i>12-11-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>RICHARD L. WHELTION</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>1017 University Blvd E Silver Spring MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/14/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven</i>	23d. LOCATION (City, town or county) (State) <i>Silver Spring Md.</i>
24. FUNERAL DIRECTOR <i>Stanley Funeral Home</i>	ADDRESS <i>3347 Ave.</i>	25a. REC'D BY REGISTRAR <i>DECEMBER 12 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Stanley Haglo</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17637

CERTIFICATE OF DEATH

17631

1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN 1b

10 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

710 Sheridan Street

3. NAME OF  
DECEASED  
(Type or print)

First  
JOSEPH

Middle  
Luther

Last  
HARTRANFT

4. DATE  
OF  
DEATH

Month  
12 - Day  
14 - Year  
1966

5. SEX  
MALE

6. COLOR OR RACE  
WHITE

7. MARRIED  
WIDOWED

NEVER MARRIED  
DIVORCED

8. DATE OF BIRTH

March 24, 1890

9. AGE (in years  
last birthday)

76  
yrs.

10. IF UNDER 1 YEAR

Months  
Days

11. IF UNDER 24 HRS

Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Machinist

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Govt.

11. BIRTHPLACE (County & State, or foreign country)

Muncy, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph W. Hartranft

14. MOTHER'S MAIDEN NAME

Elmira Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

Yes

W.W.I

16. SOCIAL SECURITY NO.

220-44-0896

17. INFORMANT

Janet B. Hartranft

Address

710 Sheridan Street  
Hyattsville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Conditions, If any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

DUE TO

(b)

DUE TO

(c)

Coronary occlusion  
Coronary arteriosclerosis

INTERVAL BETWEEN  
DNSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/18, 1966, to 12/14, 1966, that (I) (we) last saw the deceased alive on 10/18, 1966, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

R. C. Kirchner

22b. DATE SIGNED

12-14-66

22c. PHYSICIAN'S NAME (Type) R. C. KIRCHNER

22d. ADDRESS  
6480-N.H. Ave - Takoma Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF Dec. 17, 1966

23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery

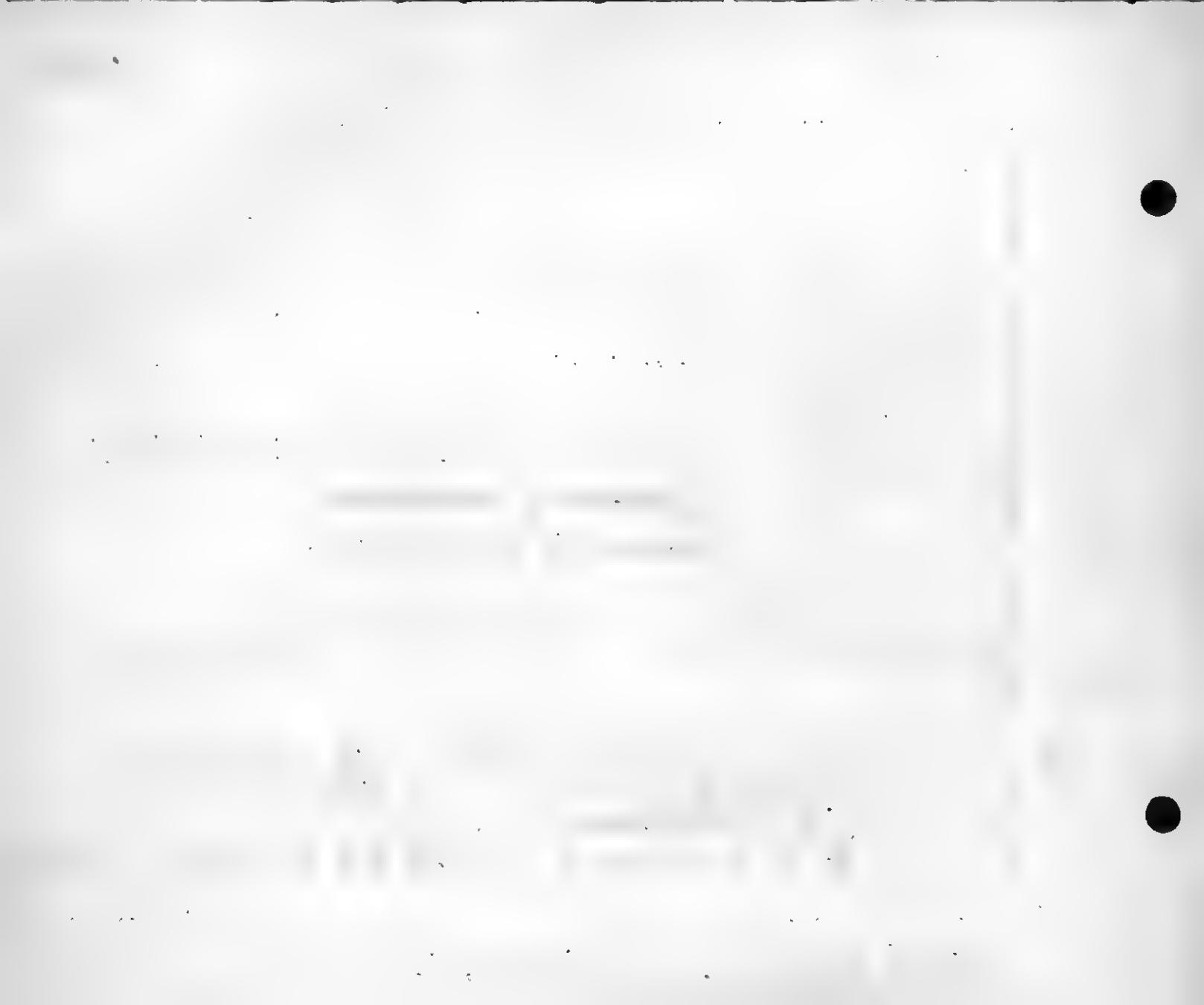
23d. LOCATION (City, town or county) (State)  
Prince Georges Co., Md.

24. FUNERAL DIRECTOR C. Glen Carter

ADDRESS 8434 Georgia Ave.

Warren E. Pumphrey, Inc. Silver Spring, Md. REC'D BY REGISTRAR REC'D 20 1966

25d. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17638

CERTIFICATE OF DEATH

17632

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HANNAH, MD.</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNIVERSITY PARK</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MAGNOLIA GARDENS NURSING HOME</b>		d. STREET ADDRESS <b>4009 TENNYSON RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MARGARET</b>	Middle <b>HEINEMAN</b>	4. DATE OF DEATH Month Day Year <b>DEC. 21 1966</b>
S. SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/83</b>
10a. US-JAP OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baldred</b>
			12. CITIZEN OF WHAT COUNTRY? <b></b>
13. FATHER'S NAME <b>Dietrich Haesloop</b>		14. MOTHER'S MAIDEN NAME <b>Julia Schmidt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	17. INFERMANT Address <b>Born 718 Murdoch Rd</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - other states</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <b>Generalized arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>450.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>diabetes mellitus.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1966</b> to <b>Dec. 21, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec. 20 1966</b> and that death occurred at <b>2:45 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Don B. Cameron</b>		22b. DATE SIGNED <b>DEC 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>DON B. CAMERON</b>		22d. ADDRESS <b>3503 PERRY ST MOUNT RAINIER, MD</b>	
23a. BURIAL, CREMATION OR BONFIRE (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 23 66 Bald</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>W. Germanna 6067 Hayford Rd</b>		23d. LOCATION (City or town) (County) (State) <b>Baldred</b>	
24. FUNERAL DIRECTOR ADDRESS <b>W. Germanna 6067 Hayford Rd</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>John J. Miller</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17639

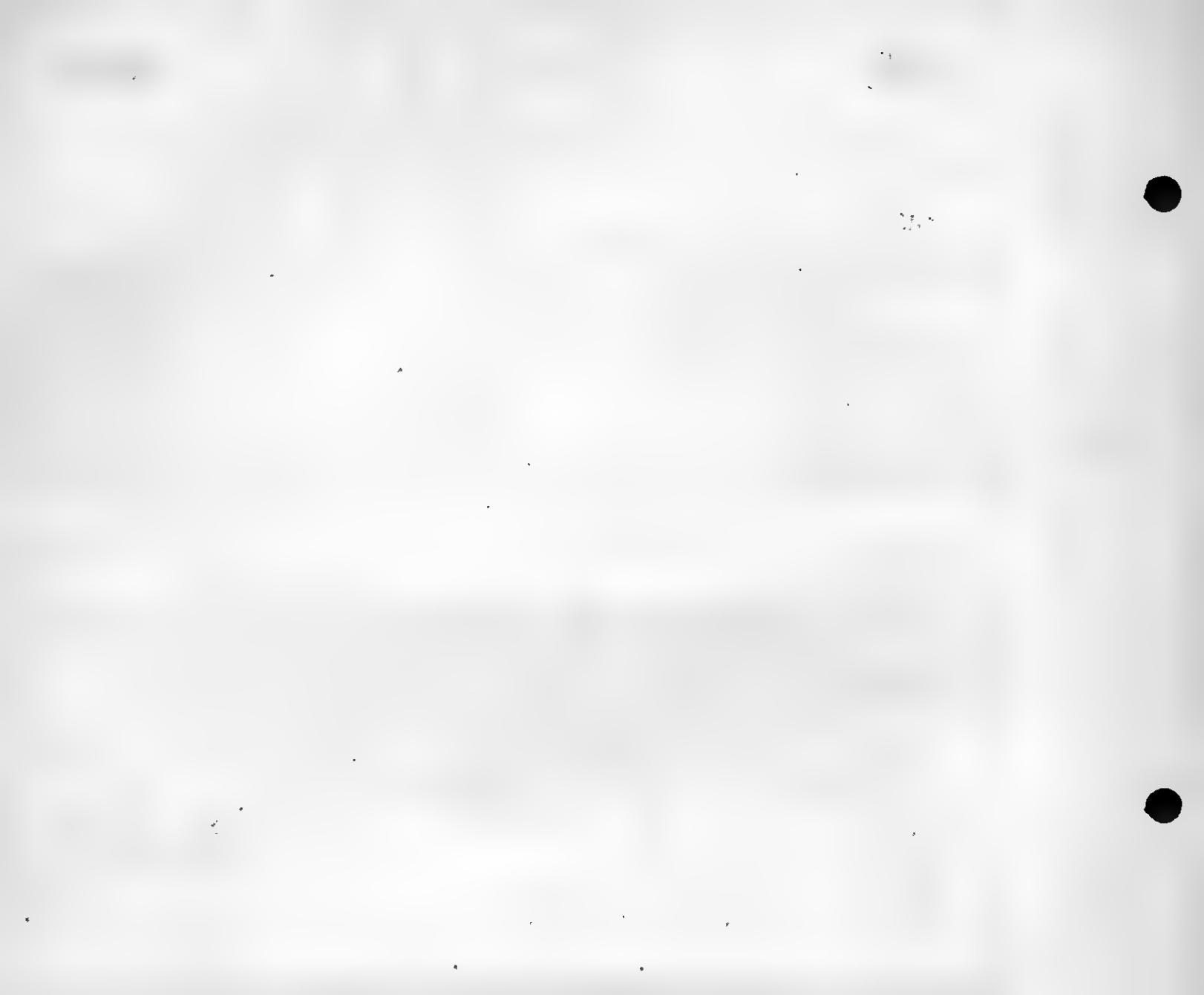
CERTIFICATE OF DEATH

17633

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>			c. LENGTH OF STAY IN lb <b>14 DAYS</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ROSAMOND</b> First <b>ADELAIDE</b> Middle <b>HELWIG</b> Last			4. DATE OF DEATH DECEMBER 20 1966		
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 DEC 1917</b>	9. AGE (In years last birthday) <b>49 yrs</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL TEACHER</b>	11. BIRTHPLACE (County & State, or foreign country) <b>GREENVILLE, N.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ZACK VAN DYKE</b>			14. MOTHER'S MAIDEN NAME <b>ADELAIDE TAFT</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT Address <b>EDWARD W HELWIG-HUSBAND-SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>WIDESPREAD METASTATIC BREAST CANCER</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>  <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF BREAST</b> <b>1 YEAR</b> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>La Plata</b>	(County) <b>Maryland</b> (State) <b>MD</b>
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>5 DEC 1966</b> to <b>20 DEC 1966</b> , that <b>1</b> (we) last saw the deceased alive on <b>20 DEC 1966</b> , and that death occurred at <b>10:55 AM</b> , from causes and on the date stated above					
22a. SIGNATURE <i>Charles D Phelps</i>		M.D. <input type="checkbox"/> ATTENDING PHYS.  <i>Charles D Phelps</i>	10:55 A.M. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.  <b>20 DEC 66</b>	22b. DATE SIGNED <b>20 DEC 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES D PHELPS, CAPT, USAF, MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 23, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	23d. LOCATION (City or Town) <b>Arlington</b>	(County) <b>Va.</b> (State) <b>VA</b>
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Juergens</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, adding in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b>		b. COUNTY <b>PRINCE GEORGE'S</b>	
c. LENGTH OF STAY IN 1b <b>4HR 15MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>5565 MAXWELL DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JANE</b>	Middle <b>CANODY</b>	Last <b>HILBISH</b>
4. DATE OF DEATH	Month <b>DECEMBER</b>	Day <b>12</b>	Year <b>1966</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
		8. DATE OF BIRTH <b>3 JUNE 1922</b>	9. AGE (In years lost birthday) <b>44 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. AIR FORCE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WOODSON, AMHURST, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE FREDERICK HILBISH</b>		14. MOTHER'S MAIDEN NAME <b>ADA LEE CANODY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>1957-PRESENT 230-28-0667</b>	
17. INFORMANT <b>OFFICIAL U.S. AIR FORCE RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>0555</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
		<i>Pneumococcal Meningitis</i>	
		<i>Pneumococcal Septicemia</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myelofibrosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>USAF HOSPITAL ANDREWS</b>
20f. (City or town) <b>ANDREWS AFB, WASHINGTON DC 20331</b>		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12 DEC 1966</b> , to <b>12 DEC 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12 DEC 1966</b> , and that death occurred at <b>11:25 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>12 DEC 66</b>	
22a. SIGNATURE <b>Walter Myalis</b>		11:25 P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12 DEC 66</b>
22c. PHYSICIAN'S NAME (Type) <b>WALTER A MYALIS, CAPT, USAF, MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS</b>	
23a. BURIAL / CREMATION / REMOVAL (Specify) <b>12/14/66</b>		23b. DATE THEREOF <b>12/14/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>AMHERST</b>
24. FUNERAL DIRECTOR <b>Mr. C. Chambers Jr. Esq. 1001 1/2 S St. NW</b>		25a. ADDRESS <b>1001 1/2 S St. NW</b>	25b. LOCATION (City or Town) (County) (State) <b>AMHERST, VA</b>
		25c. REC'D BY REGISTRAR <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17641

CERTIFICATE OF DEATH

17635

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

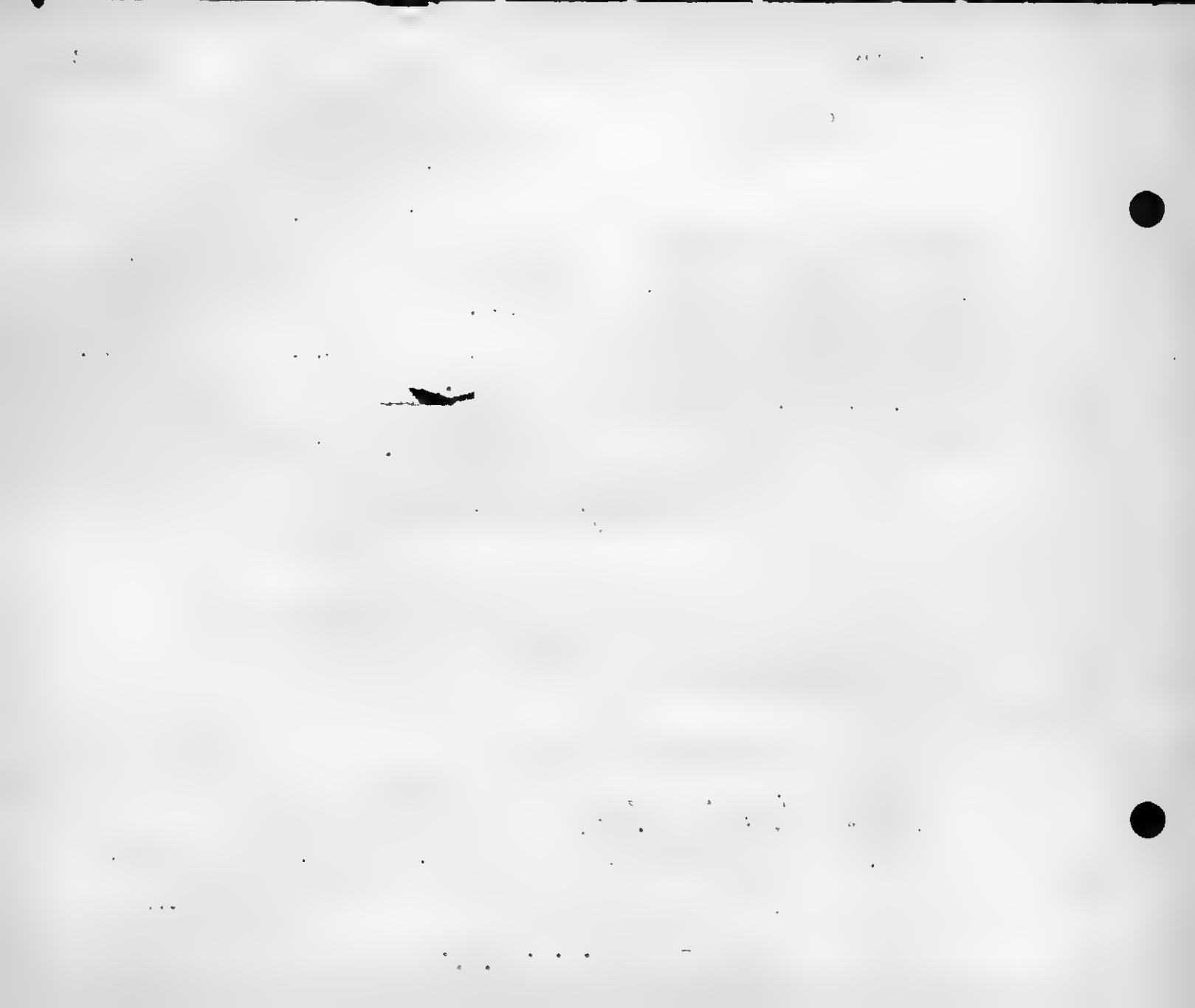
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate lim's, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Washington, D.C.</b>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>			
3. NAME OF DECEASED (Type or print)		First <b>Carl</b>	Middle <b>Edmund</b>	Lost	4. DATE OF DEATH <b>12-28-66</b>	Month 12	Day 28	Year 1966	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH <b>10-8-06</b>	9. AGE (In years last birthday) <b>60</b> yrs	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contracting</b>		11. BIRTHPLACE (County & State, or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samples</b>				14. MOTHER'S MAIDEN NAME <b>UNK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>578-24-031</b>		17. INFORMANT <b>Medical Records/ Anne Armentrout, daughter.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>42-51</b>		DUE TO (b)  DUE TO (c)		<b>Coronary Occlusion</b> <b>Arteriosclerotic HT Disease</b> <b>Arteriosclerosis Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-39 1/2</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus 3 yrs c. Gangrene of RT foot 6 mo</b>									
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>12-28-66</b>		(County) _____	(State) _____
21. I certify that (I) <b>(This hospital)</b> attended the deceased from <b>12-6-</b> , 19 <b>66</b> , to <b>12-28-, 19 66</b> that (I) <b>(was)</b> last saw the deceased alive on <b>12-27- 1966</b> , and that death occurred at <b>1135</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>Walcutt G. Gibson</b>						22b. DATE SIGNED <b>12-28-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Walcutt Gibson, M.D.</b>		22d. ADDRESS <b>4340 St. Barnabas Rd., Marlow Heights,</b>						Md. 20031	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12/31/66 Wash. Nat'l</b>		23b. DATE THEREOF <b>12/31/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Wash. Nat'l</b>		23d. LOCATION (City or Town) <b>Pr. Geo. Co. MD</b>		(County) _____	
24. FUNERAL DIRECTOR <b>W.C. Chambers Co. Inc 512 N. E. St.</b>		ADDRESS <b>100 E. 3rd St.</b>		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Geary</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										17636			
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					b. COUNTY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>Prince George General Hospital</b>					7204 Wells Blvd.								
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>	Middle <b>LEWIS</b>	Last <b>HOLTHAUS</b>	4. DATE OF DEATH December 27, 1966		Month Year	Day	Year				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1905	9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles L. Holt haus					14. MOTHER'S MAIDEN NAME Tower Charlotte Tower								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No				Margaret G. Holthaus-wife same 2d									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>													
420.1 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)			
19													
21. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>66</b> , to <b>12/21</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.										22b. DATE SIGNED			
22a. SIGNATURE <b>Dr. C. Wainwright</b>		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles H. Wainwright</b>		22d. ADDRESS <b>9 EE Chase St., Baltimore, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Glenwood Cemetery</b>		23d. LOCATION (City, town or county) <b>Washington D.C.</b>		(State)					
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. J. 1966</b>							



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

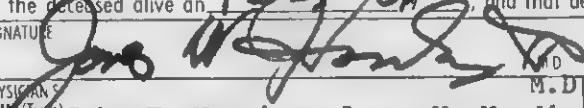
17643

CERTIFICATE OF DEATH

17637

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Carroll Maryland Prince Georges</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>7504 Dover Lane</b>		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>F</b>	Middle <b>Horrigan</b>	4. DATE OF DEATH <b>Dec. 5 1966</b>	Month <b>Dec.</b> Day <b>5</b> Year <b>1966</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Nov., 1899</b>	9. AGE (In years last birthday) <b>67 yrs</b>	10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Funeral Director</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington D. C.</b>	
13. FATHER'S NAME <b>Thomas Horrigan</b>			14. MOTHER'S MAIDEN NAME <b>Mary Cunningham</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>May E. Horrigan 7504 Dover Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1</b> DUE TO <b>cardiac deility</b> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>carcogenous neoplasia</b> (c) DUE TO <b>prostatic carcinoma of prostate</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>1964</b> (County) <b>12-5</b> (State) <b>1965</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , 19, to <b>12-5</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>12-3-64</b> , and that death occurred at <b>11, 45 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE 		22b. DATE SIGNED <b>12/6/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>James W. Harding</b>		22d. ADDRESS <b>7601 Riverdale Rd., Lanham, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/9/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cemetery</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 9 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17644

CERTIFICATE OF DEATH

17638

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Magnolia Gardens Nursing Home			d. STREET ADDRESS 3917 Commander Drive		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First LYDIA Middle MATILDA Last HOUSER			4. DATE OF DEATH Dec. 10, 1966 Day 19 Year 66		
S SEX Female	6 CO. OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 12, 1879	9 AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		
11. BIRTHPLACE (County & State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Christian Metzger			14. MOTHER'S MAIDEN NAME Priscilla Zettlemoyer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213 56 2465		17. INFORMANT Address Phyllis M. Lovell, Same as #2 (daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>In myocardial failure</i> <i>Central artero-sclerosis, old, c</i> <i>Generalized Hemiplegia</i> <i>Generalized artero-sclerosis</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1959, 19 to 19, 19, that (I) (we) last saw the deceased alive on 12/17/66 19, and that death occurred at 15 M, from causes and on the date stated above.					
22a. SIGNATURE <i>Etienne</i>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/10/66	
22c. PHYSICIAN'S NAME (Type) Walcott Etienne, M. D.			22d. ADDRESS Berwyn Road College Park, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 13, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Ab Lincoln Cemetery Colmar Manor Burw Rd Md	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS F Guccio sons Hyattsville Md -			25a. SIGNED BY REGISTRAR DATE DEC 15 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17645

## CERTIFICATE OF DEATH

17639

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Item, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or autopsy, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Pro Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6208 57th avenue			d. STREET ADDRESS 6208 57th avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First John M. Middle Hutchens sr		Last		4 DATE OF DEATH Dec 13, 1966	Month	Day	Year
S. SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 15, 1902	9 AGE (In years last birthday) 64 yrs.	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Railroad cars		11 BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Reyton Hutchens			14. MOTHER'S MAIDEN NAME Rose Shea				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) yes WWI		16. SOCIAL SECURITY NO		17. INFORMANT Evelyn Mc Kenzie Adelphi, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>month</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension Heart Disease</u> 5 years (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Angina pectoris</u>							
20c. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 19</u> , 1966 to <u>Dec 12</u> , 1966, that (I) (we) last saw the deceased alive on <u>Dec 12</u> , 1966, and that death occurred at <u>8 AM</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Chas. V. Payne</u> 22b. DATE SIGNED <u>12/13/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>Chas. V. PAYE MD.</u>		22d. ADDRESS <u>7520 Remondale Rd Hyattsville Md.</u>					
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 16, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE DEC 19 1966		25b. REGISTRAR'S SIGNATURE <u>Chas. V. Payne</u>



2



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 6 Film 553 16/16/66 mh

17646

CERTIFICATE OF DEATH

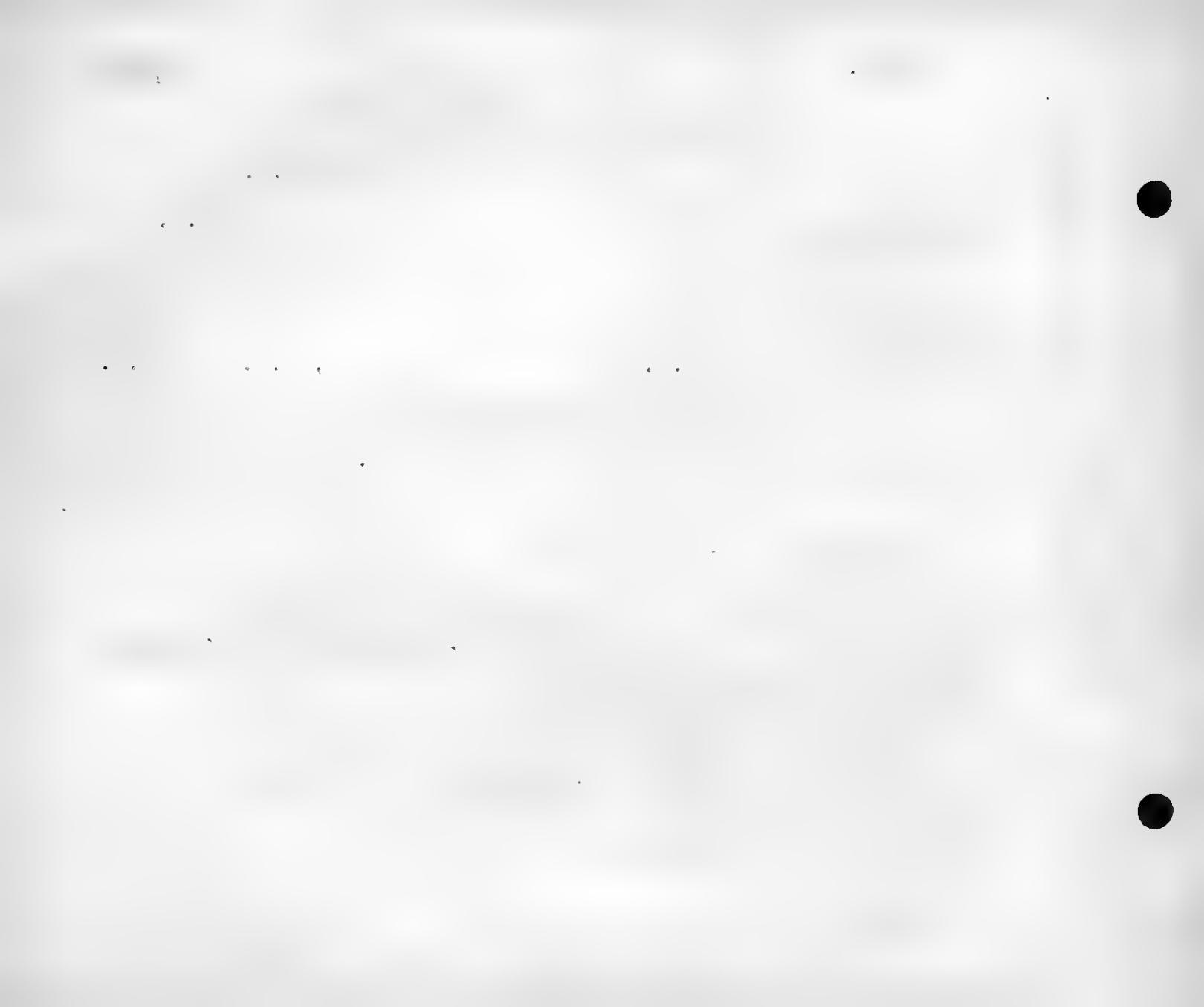
17640

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician.

director, page 3 should be detached for use as the burial-transit permit. Then please file above carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY <b>Prince George</b>		b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
f. STREET ADDRESS <b>2708 30th Street S.E.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAUL</b>		4. DATE OF DEATH <b>JOHNSON Dec 5th 1966</b>	
First	Middle	Last	Month
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 2nd 1881</b>
9. AGE (In years lost birthday) <b>85 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Month <b>Dec</b>
13. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	14. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy Yard</b>	15. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
17. FATHER'S NAME <b>John Johnson</b>		18. MOTHER'S MAIDEN NAME <b>Mary Ellen Kelliher</b>	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1900-1904</b>		20. SOCIAL SECURITY NO <b>578-66-8813</b>	
21. INFORMANT <b>Florence M. Johnson Same as # 2</b>		22. ADDRESS	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>7221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Dyslipidemia &amp; Dehydration</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 whs</b>	
(b) DUE TO DUE TO (c) <b>Dyslipidemia of both feet</b>		24. INFORMANT <b>Generalized Arteriosclerosis 10 yrs</b>	
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile brain syndrome due to ASCVD</b>		26. INJURY OCCURRED When Hour a.m. p.m. <b>19</b>	
27. TIME OF INJRY Month, Day, Year Hour a.m. p.m. <b>11/21/66</b>		28. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.) <b>11/21/66 to 12/5/66</b>	
29. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>12/4/66</b> , and that death occurred at <b>11:00 PM</b> , from causes and on the date stated above.		30. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
31. SIGNATURE <b>Kelvin L. Minchin</b>		32. DATE SIGNED <b>12/5/66</b>	
33. PHYSICIAN'S NAME (Type) <b>KELVIN L. MINCHIN</b>		34. ADDRESS <b>6400 MARLBORO PINES</b>	
35. BURIAL, CREMATION, (Specify) <b>Burial</b>		36. DATE THEREOF <b>12-9-1966</b>	
37. FUNERAL DIRECTOR <b>Gates &amp; Mattingly</b>		38. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat'l</b>	
39. ADDRESS <b>131-117th St</b>		40. LOCAT.ON (City or Town) <b>Fort Myer Va</b>	
41. RECD BY REGISTRAR <b>Charles Judge</b>		42. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17647

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17641

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roy Chancellor Jones</b>		4. DATE OF DEATH Month <b>12</b>	Month Day <b>16 19 66</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WOOED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Year <b>6 March 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	9. AGE (In years last birthday) yrs <b>86</b>
13. FATHER'S NAME <b>James T. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Susan J. Grimsley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <b>1901 - 1905</b>		16. SOCIAL SECURITY NO <b>579 03 5935</b>	17. INFORMANT Address <b>Anne L. Jones Same as #2 (neice)</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, I.D.</b>		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <b>Riverdale, Md.</b>			
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/20/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Arlington Va.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REG STRAR DATE <b>DEC 22 1966</b>
			25b. REG STRAR'S SIGNATURE <i>Charles Judge</i>

1

2 3 4

5 6 7 8 9

10 11 12

13

14 15 16 17

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

17642

17648  
1. PLACE OF DEATH  
o COUNTY

Prince Georges County MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

College Park

c. LENGTH OF STAY IN lb

40 Years

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

College Park

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

5012 Hollywood Road

d. STREET ADDRESS

5012 Hollywood Road

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

12

20

1966

## 5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)  
yrs.

Oct. 8, 1891

10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Store Owner

11. BIRTHPLACE (State or foreign country)

Religious Articles St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Thomas G. O'Reilly

## 14. MOTHER'S MAIDEN NAME

Charlotte Schemmel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes or no or unknown)

(If yes, give war or dates of service)

No

None

## 16. SOCIAL SECURITY NO.

Unknown

## 17. INFORMANT

Marguerite O'Reilly Reitz, Rd. College Pk.

Address 5012 Hollywood

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

(b)

DUE TO

(c)

Carcinoma of Colon  
with MetastasesINTERVAL BETWEEN MD.  
ONSET AND DEATH

6 mo.

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY Month, Day, Year

Hour  
p. m.

19

## 20d. INJURY OCCURRED

White  
at work  Not white  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Dec. 8, 1966, to Dec. 30, 1966, that I last saw the deceased alive on Dec. 12, 1966, and that death occurred at 11 a.m. from the causes and on the date stated above.

ACTUAL  
SIGNATURE

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S  
NAME (Type)

L W Malin M.D.

Riverdale, Maryland

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec. 23, 1966

## 22c. NAME OF CEMETERY OR CREMATORIUM

St. Joseph's Cemetery

## 22d. LOCATION (City, town, or county)

(State)

East McKeesport, Pennsylvania

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

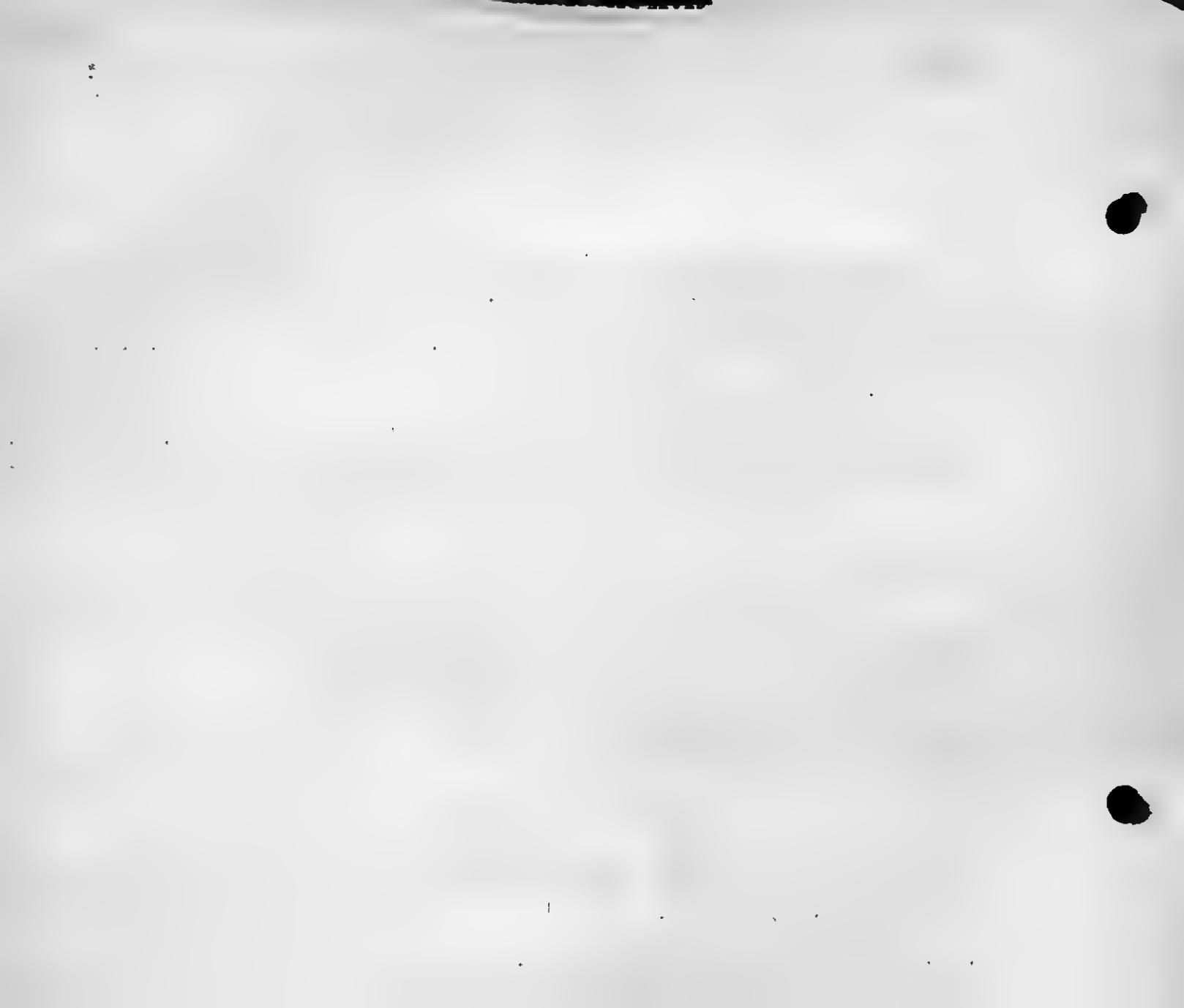
24a. REC'D BY REGISTRAR

## 24b. REGISTRAR'S SIGNATURE

W. W. CHAMBERS CO., Riverdale, Md.

DATE 27 1966

Burke Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17643

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be given to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17649

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George General Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

Kendrick

Month

Day

Year  
12 7 19 664. DATE OF  
DEATH

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

9. AGE (in years  
less birthday)

10. FUNDER 1 YEAR

11. FUNDER 24 HRS.

Months Days Hours Min.

Male

White

7-19-1909

57 yrs.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR  
INDUSTRY

U. S. Govt

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

13. FATHER'S NAME

John James Kendrick

14. MOTHER'S MAIDEN NAME

Blanche Roberson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown)  (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

577-28-4478

17. INFORMANT

John Kendrick

18. INTERVAL BETWEEN  
ONSET AND DEATH

Address 59th Avenue

Hillside, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute pulmonary edema, bilateral, severe

INTERVAL BETWEEN  
ONSET AND DEATH

52 X

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO

(Etiology undetermined)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County) (State)21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

John Kehoe, M.D. Riverdale, Md.

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

22. DATE SIGNED

12-9-66

Address (Street, city, town, or county)

23a. BURIAL/CREMATION  
BUT NOT BOTH (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION (City, town or county) (State)

Burial

12-12-1966

Cedar Hill

Suitland, Md

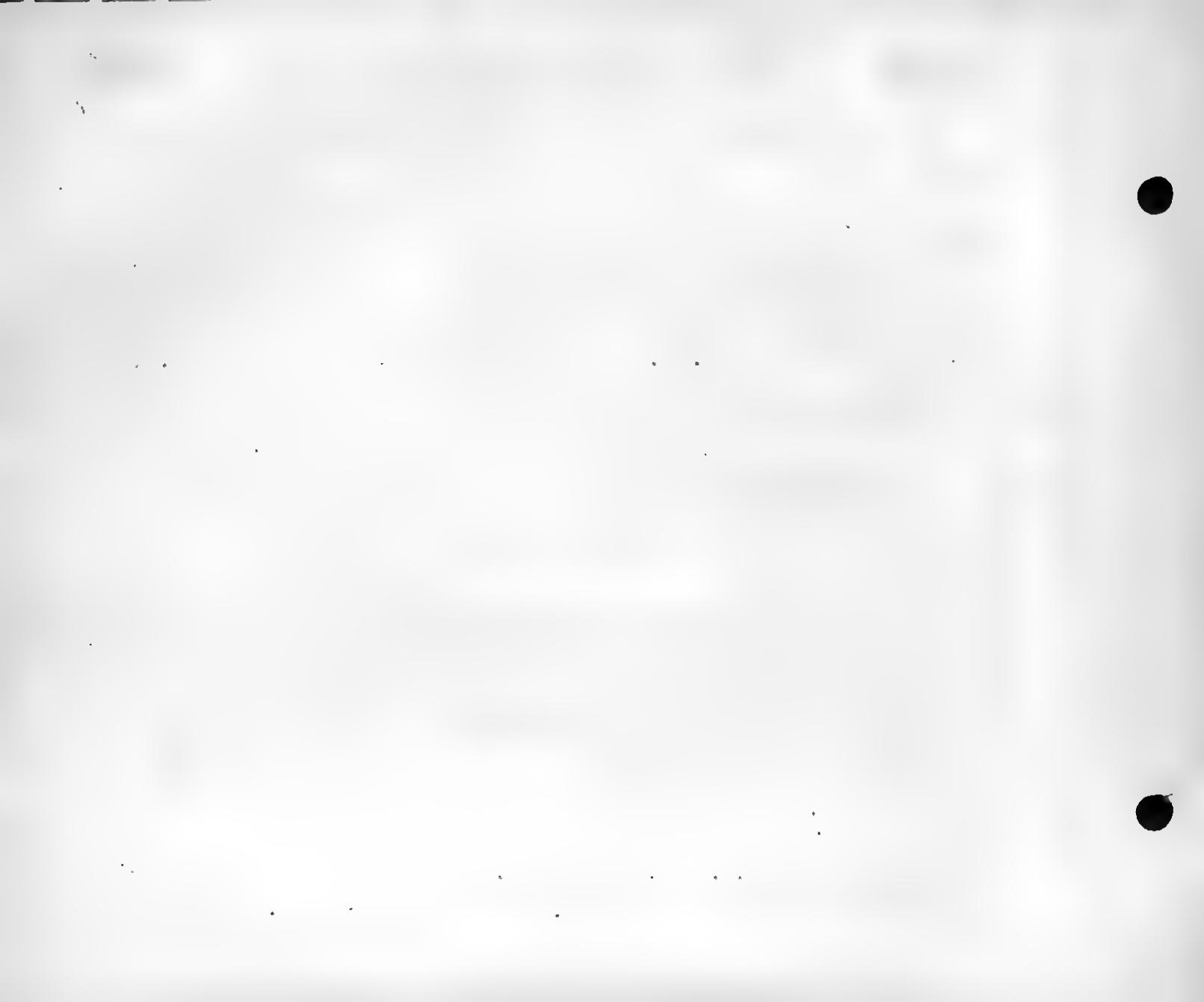
24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Robert A. Matthews

131-11-288-Wh-3AC

DATE DEC 15 1966

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17650

CERTIFICATE OF DEATH

17644

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb <b>3 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ada C Kidwell</b>			First	Middle	Last	
4. DATE OF DEATH <b>Dec. 23 1966</b>			Month	Doy	Year	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>27 Sept. 1879 86 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
11. BIRTHPLACE (County & State or foreign country) <b>Berkley Springs, W. Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert A. Heitt</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Powell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>213-18-2170</b>			
17. INFORMANT <b>Mr. Melvin A. Kidwell (Abbey address)</b>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>			INTERVAL BETWEEN ONSET AND DEATH			
DUE TO <b>14330</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Advanced arteriosclerotic cardiac vascular disease</b>						
DUE TO <b>(b)</b>						
DUE TO <b>(c)</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or Town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12-20 1960</b> , to <b>12-22 1966</b> , that (I) (we) last saw the deceased alive on <b>12-22 1966</b> , and that death occurred at <b>3:45 AM</b> from causes and on the date stated above.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <b>John R. Lilly</b>			22b. DATE SIGNED <b>12-23-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>John R. Lilly, M.D.</b>			22d. ADDRESS <b>4410 74th Ave., Bellemere, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Burtonsville Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Burtonsville, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>1st. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17645

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		d. STREET ADDRESS <b>5805 Carlyle St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Warner</b>		First <b>Robert</b>	Middle <b>Warner</b>
3. NAME OF DECEASED (Type or print) <b>Robert Warner</b>		4. DATE OF DEATH Year <b>1921</b>	Month <b>12</b>
3. NAME OF DECEASED (Type or print) <b>Robert Warner</b>		Doy <b>18</b>	Year <b>1966</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>30 Nov., 1921</b>
9. AGE (In years last birthday) <b>45</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>	11. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON GASLIGHT CO.</b>	12. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>
13. FATHER'S NAME <b>ROBERT E. KIRK</b>	14. MOTHER'S MAIDEN NAME <b>ALICE MYERS</b>	15. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIA. SECURITY NO <b>57788414</b>	18. INFORMANT <b>NATALIE B. KIRK</b>
		Address <b>SAME AS #2</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH Minutes <b>over 5 yrs</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <i>John Kehoe</i>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, M.D., Riverdale</b>	
24. DATE SIGNED <b>12-18-66</b>		25. DATE THEREOF <b>12-21-1966</b>	
26. NAME OF CEMETERY OR CREMATORIAL <b>FORT LINCOLN CEM. BLADENSBURG, MARYLAND</b>		27. LOCATION (City or Town) (County) (State) <b>MARYLAND</b>	
28. FUNERAL DIRECTOR <b>W.W. Chamberlain &amp; Co. Riverdale, Md.</b>		29. ADDRESS <b>ADDRESS</b>	
30. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		31. RECEIVED BY REGISTRAR <b>DEC 27 1966</b>	
32. REGISTRAR'S SIGNATURE <i>John Kehoe</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17652

## CERTIFICATE OF DEATH

Reg. Dist. No.

17646

1. PLACE OF DEATH a. COUNTY <i>Prince George County MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marlow Heights</i>		b. COUNTY <i>Prince George</i>	
c. LENGTH OF STAY IN lb <i>8 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marlow Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4830 Oxford Drive</i>		d. STREET ADDRESS <i>4830 Oxford Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MALCOLM A KLINE</i>		First <i>A</i>	Middle <i></i>
4. DATE OF DEATH <i>December 2 1966</i>		Last <i>KLINE</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/28/1907</i>
9. AGE (In years less birthday) <i>59 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>construction</i>	11. BIRTHPLACE (State or foreign country) <i>Palmerton, Pa.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>AUGUST KLINE</i>	14. MOTHER'S MAIDEN NAME <i>EMMA LIEBENGUTH</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO <i>179-05-504</i>	17. INFORMANT <i>EMMA Roberts SEE #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PULMONARY EDEMA HYPERTENSIVE HEART DISEASE 12 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>CIRRHOSIS OF LIVER</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>5/11 1965</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>4400 Stamp Road, Temple Hills, Md.</i>	
21. I certify that I attended the deceased from _____ 5/11, 1965, to 12/2, 1966, that I last saw the deceased alive on 12/2/66, 1966, and that death occurred at 4 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bruno Kolega</i>		ADDRESS (Street, city or town, state) <i>4400 Stamp Road, Temple Hills, Md.</i>	
DATE SIGNED <i>12/2/66</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>12/2/66</i>	22c. NAME OF CEMETERY OR Crematory <i>Indian Land</i>
22d. LOCATION (City, town, or county) <i>Cherryville, Penna</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS CO.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 3 1966</i>	24b. REGISTRAR'S SIGNATURE <i>W.W. Chambers Co.</i>
ADDRESS 517 11/3 ST S.E <i>Wash. D.C.</i>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**17653**

**CERTIFICATE OF DEATH**

**17647**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Prince George MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham		b. COUNTY Prince George	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7304 Riverdale Road		d. STREET ADDRESS 7304 Riverdale Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carolyn	Middle Gress	Last Knapp
4. DATE OF DEATH	Month 12	Day 6	Year 1966
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-80
Female	Cauc.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Gress		14. MOTHER'S MAIDEN NAME Phoebe Wickizer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 562-42-3733 Mrs. Dewey T Jones - Same as #2d	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Failure</i>			
420.0 DUE TO <i>Arterosclerotic heart disease</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i>			
DUE TO <i>Ca of blast</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 to 12/16, 1966, that (I) (we) last saw the deceased alive on 9/17 1966, and that death occurred at <i>DC</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>K James Shortz</i>		22b. DATE SIGNED <i>12-6-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>A James Shortz</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF 12-6-66	
23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Lee Funeral Home, 3004th St, NE, Wash,		25a. REC'D BY REGISTRAR DC DATE DEC 9 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17654

## CERTIFICATE OF DEATH

17648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>GRACE</b>	Middle <b>TAYLOR</b>	Last <b>KOON</b>
4. DATE OF DEATH	Month <b>28 DECEMBER</b>	Day <b>1966</b>	Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 APRIL 1891</b>
9. AGE (in years last birthday) <b>75 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (County & State, or foreign country) <b>PHILADELPHIA, PA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>CHARLES AUGUSTUS FEATHER</b>		
14. MOTHER'S MAIDEN NAME <b>ISABELL ADAIR</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>N/■</b>	17. INFORMANT <b>RAYMOND G. BOURASSA SON-IN-LAW</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory + cardiac failure</i>	INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>		
DUE TO (b) Cconditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.	<i>Generalized arteriosclerosis, severe</i>		
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Complete heart block, chronic cholecystitis &amp; cholelithiasis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>20 Dec 1966</b> to <b>28 Dec 1966</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>27 Dec 1966</b> , and that death occurred at <b>0915 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Philip A. Cox, Col.</i>	22b. DATE SIGNED <b>28 Dec 66</b>		
22c. PHYSICIAN'S NAME (Type) <b>PHILIP A. COX, COL, USAF, MC</b>	M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 22d. ADDRESS <b>ANDREWS AFB USAF HOSPITAL ANDREWS, WASH, D.C. 20331</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-31-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>New Camden Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Camden New Jersey</b>
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>	ADDRESS <b>4308 Suitland Rd Suitland Maryland</b>	25a. REC'D BY REGISTRAR <b>JILL J. 3</b>	25b. REGISTRAR'S SIGNATURE <i>Jill J. 3</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
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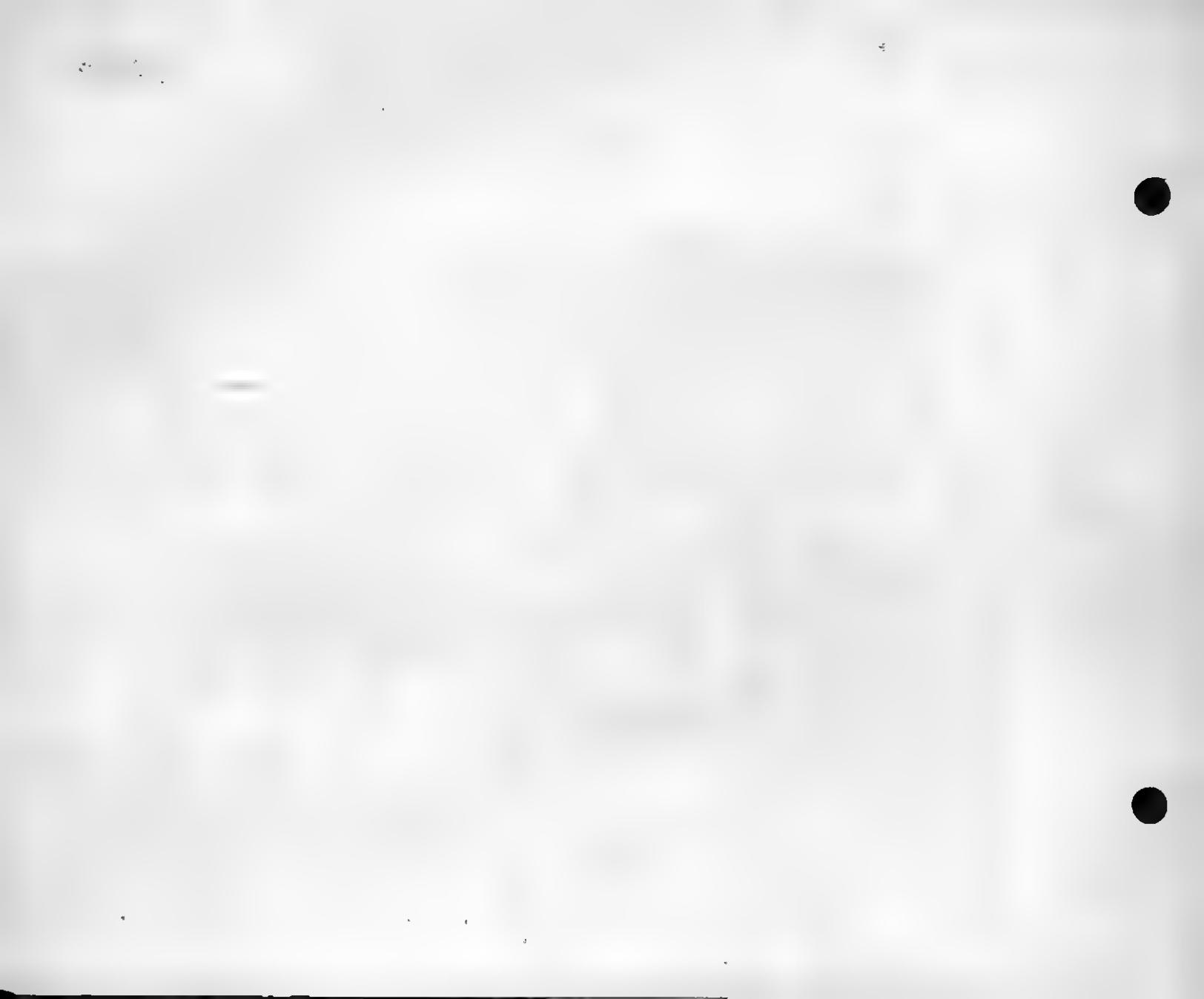
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17555

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17649

1. PLACE OF DEATH a. COUNTY Prince George's County Maryland		2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. STATE Md b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 17 years.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5902 15th Ave., Hyattsville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard		First D.	Middle LANKFORD Last
4. DATE OF DEATH December 25		Month	Day Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1895
9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABILITY (VETERAN)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME MARTHA ANN O'Neil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI 1918		16. SOCIAL SECURITY NO. 220-50-9049 RUSSELL E. REID Address 5902 15th Ave., Hyattsville, Md.	
17. INFORMANT Severe Pulmonary Emphysema		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Pulmonary Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchitis DUE TO (c) Smoking	
		INTERVAL BETWEEN ONSET AND DEATH 25 YEARS.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December 19, 1966, to December 20, 1966, that (I) (we) last saw the deceased alive on December 20, 1966, and that death occurred at 11:20 PM, from the causes and on the date stated above.		22b. DATE SIGNED 12/26/66	
22a. SIGNATURE Hugo G. Graziani		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. ADDRESS 11612 STEWART LANE, B2, SILVER SPRING, MD.
22c. PHYSICIAN'S NAME (Type) Hugo G. Graziani, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 12/29/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Nat. Cemetery, Mt. Rainier, Maryland	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		23d. LOCATION (City, town or county) Arlington, Va. 25a. REC'D BY REGISTRAR DATE JAN 3 1967 25b. REGISTRAR'S SIGNATURE Maryland	
		15M 4-64	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17656

CERTIFICATE OF DEATH

17656

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>		c. LENGTH OF STAY IN b <b>1b</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>PRINCE GEORGES</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1907 GAYLORD DRIVE S. E.</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>					
3. NAME OF DECEASED (Type or print)		First <b>DAVID</b>	Middle <b>G.</b>	Last <b>LASHER</b>	4. DATE OF DEATH <b>DECEMBER 12 1966</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <b>AUGUST 8, 1880</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MANFG.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>GEORGE LASHER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET DUTCHER</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>VELMA BEYER 1907 GAYLORD DRIVE S. E.</b>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  151X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.  DUE TO (b) DUE TO (c)		<i>Gastric Carcinoma c pulmonary metastases</i>				INTERVAL BETWEEN ONSET AND DEATH <i>approx 1yr</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>LOCK BERLIN</b>		(County) <b>NEW YORK</b>		(State) <b>NY</b>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>5P M</b> , from causes and on the date stated above.											
22a. SIGNATURE <i>John F. Shay</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec 19 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. SHAY</b>		22d. ADDRESS <b>5509 Old Fiber Hill Rd, Suitland Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>12/14/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>LOCK BERLIN CEMETERY</b>		23d. LOCATION (City or Town) <b>LOCK BERLIN</b>		(County) <b>NEW YORK</b>		(State) <b>NY</b>	
24. FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b>		ADDRESS <b>4308 SUITLAND ROAD S. E. SUITLAND MD.</b>		25a. RECD BY REGISTRAR <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17657

17651

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits,  
write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George General Hospital

## 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hillcrest Heights

## d. STREET ADDRESS

5009 Dixon Street

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

## 5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Male

White

WIDOWED DIVORCED 

12-31-1907

Months

Days

Hours

Min.

58 57 yrs.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT  
COUNTRY

## 13. FATHER'S NAME

JESSE H. LAUGHTER

## 14. MOTHER'S MAIDEN NAME

Lydia MOFFIT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

679-03-5869

## 17. INFORMANT

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart failure

INTERVAL BETWEEN  
ONSET AND DEATH  
minutes

DUE TO Arteriosclerotic heart disease

over 5 yrs.

Conditions, If any, which  
gave rise to Immediate  
cause (s), stating the  
underlying cause last.

(b)

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes mellitus - over 10 years

19. WAS AUTOPSY  
PERFORMED?YES  NO 

## 20a. EXTERNAL CAUSE WAS

PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.20d. INJURY OCCURRED  
While  
at work  Not While  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

John Kehoe, M.D.

Riverdale, Md.

Address (Street, city, town, or county)

22. DATE SIGNED

CHIEF MEDICAL EXAMINER M.O. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

12-8-66

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

12/12/66

## 23b. DATE THEREOF

FT. Lincoln

## 23c. NAME OF CEMETERY OR CREMATORI

## 23d. LOCATION (City, town or county) (State)

Bladensburg MD.

## 24. FUNERAL DIRECTOR

ADDRESS

W.A.T. DC.

## 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE DEC 12 1966

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17658

CERTIFICATE OF DEATH

17652

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN b <b>3 yr. 2 mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
3. NAME OF DECEASED (Type or print) <b>Susie</b>		d. STREET ADDRESS <b>511 5th St., N.W.</b>	
3. SEX <b>F</b>	4. FIRST MIDDLE <b>Susie</b>	5. LAST <b>Lawrence</b>	6. DATE OF DEATH <b>12/7/71</b>
7. COLOR OR RACE <b>N</b>	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	9. NEVER MARRIED DIVORCED <input type="checkbox"/>	10. AGE (in years last birthday) <b>80 yrs</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	12. KIND OF BUSINESS OR INDUSTRY	13. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>
15. FATHER'S NAME <b>Austin Tate</b>		16. MOTHER'S MAIDEN NAME <b>Betty ?</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	18. SOCIAL SECURITY NO. <b>unknown</b>	19. INFORMANT <b>decedent</b>	20. ADDRESS
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>54/1</b> { b) <b>Perforation of duodenal ulcer</b> DUE TO <b>Multiple duodenal ulcers</b> (c) <b>(with penetration into the pancreas)</b>			22. INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>diabetes mellitus; left radical mastectomy for carcinoma of the breast 11/62; total hysterectomy, 12/63; chronic pyelonephritis.</b>			23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
26. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	27. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	28. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	29. (City or town) (County) (State)
30. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/14/63</b> to <b>12/7/66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/7/66</b> , and that death occurred at <b>6:15 P.M.</b> , from causes and on the date stated above.			
31. SIGNATURE <b>Moe Weiss</b>		32. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	33. DATE SIGNED <b>12/7/66</b>
34. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		35. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
36. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	37. DATE THEREOF <b>12/14/66</b>	38. NAME OF CEMETERY OR CREMATORIAL <b>Church Cemetery</b>	39. LOCATION (City or Town) (County) (State) <b>Westmorland City, Va.</b>
40. FUNERAL DIRECTOR <b>Lowe's 7 Home</b>		41. ADDRESS <b>1425 Madison</b>	42. REC'D BY REGISTRAR DATE <b>DEC 14 1966</b>
			43. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17659

CERTIFICATE OF DEATH

17653

PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>	c. LENGTH OF STAY IN lb <b>2 Months</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill, Maryland</b>	b. COUNTY <b>Pr. Geo's</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>		d. STREET ADDRESS <b>915- Palmer Road SE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ALBERT</b>	Middle <b>LEBERT</b>	Last 4. DATE OF DEATH <b>Dec. 7th</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20- 1901</b>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Potomac Electric Power Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New Jersey</b>	9. AGE (In years last birthday) <b>65 yrs</b>
13. FATHER'S NAME <b>Oliver Lebert</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Frazerd</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT <b>Kenneth A. Lebert (Son)</b> Same as # 2.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cocciomatosis from Carcinoma of Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3dm</b>	
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cocciomatosis from Carcinoma of Prostate</b>		<b>6 mo</b>	
(c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cocciomatosis from Carcinoma of Prostate</b>		<b>11 mo</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <b>10/18/66</b> to <b>12/7/66</b> that (I) (we) last saw the deceased alive on <b>12/6/66</b> , and that death occurred at <b>7pm</b> from causes and on the date stated above.		20f. (City or town) <b>7pm</b> (County) <b>1000</b> (State) <b>DC</b>	
22a. SIGNATURE <b>Kelvin L. Minchin</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <b>12/7/66</b>
22c. PHYSICIAN'S NAME (Type) <b>KELVIN L. MINCHIN</b>		22d. ADDRESS <b>6400 MARLBORO PINE</b>	
23a. BURIAL, CREMATION, REMOVAL. (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 10-1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>St. John's Cemetery</b>
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		ADDRESS <b>1661- Gd. Hope Rd. SE. Wash., DC</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 12 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 1 in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 1, 3 & 14 Item #G393 1/5/66 PC

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17654

1 PLACE OF DEATH a. COUNTY  Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Cheverly D.C.		c. LENGTH OF STAY IN lb Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 1224 C St., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First: Randolph Middle: Lee		4 DATE OF DEATH Month: 12 Day: 3 Year: 1966	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Mar., 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Conc't	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Moses Lee		14. MOTHER'S MARRIED NAME Minnie Glechmond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Carrie Lee		Address 1234 E St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause just		INTERVAL BETWEEN ONSET AND DEATH Minutes	
(b) Laceration of abdominal wall and amputation of rt leg. DUE TO Trauma auto accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by auto	
20c. TIME OF INJURY Month, Day, Year Hour AM 10:45 pm 12 3 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Balt. Wash Parkway nr rt 212, P.G.		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Lehoë, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Riverdale	
22. DATE SIGNED 12-5-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 15-9-66	
23c. NAME OF CEMETERY OR CREMATORIAL Church		23d. LOCATION (City or Town) (County) (State) Farmville, VA	
24. FUNERAL DIRECTOR W.H. Bacon		ADDRESS 1722 7th St. NW	
25a. REC'D BY REGISTRAR DATE DEC 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17661

CERTIFICATE OF DEATH

17655

1. PLACE OF DEATH  
a. COUNTY

PRINCE GEORGE'S

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HYATTSVILLE

c. LENGTH OF STAY IN 1B  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

8910 RIGGS ROAD

3. NAME OF  
DECEASED  
(Type or print)

MARIE L'ISE  
(MOTIER ST. JEAN BAPTISTE DELASALLE)

5. SEX

6. COLOR OR RACE

FEMALE

WHITE

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

EDUCATION

13. FATHER'S NAME

HENRY LESSARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  
(Yes, no, or unknown) (If yes, give rank, dates of service)

NO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

443X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Congestive Heart Failure

Hypertensive cardiovascular disease

INTERVAL BETWEEN  
ONSET AND DEATH

48 hrs.

54 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 20d. INJURY OCCURRED Month, Day, Year  
p.m. 19 While  Not While   
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from DEC. 1, 1966 to DEC. 8, 1966 that (I) ( ) last saw the deceased alive on DEC. 8, 1966, and that death occurred at 8:45 A.M. from the causes and on the date stated above.

22. SIGNATURE

James L. Hawbeck, M.D.

22c. PHYSICIAN'S  
NAME (Type)

James L. Hawbeck, M.D. 1903 Wooded Way, Adelphi, Md.

22b. DATE  
SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL 12-10-66

23c. NAME OF CEMETERY OR CREMATORIAL

VILLA AUGUSTINA CEM.

23d. LOCATION (City, town or county)

GOFSTOWN,

(State)

N.H.

24. FUNERAL DIRECTOR'S SIGNATURE

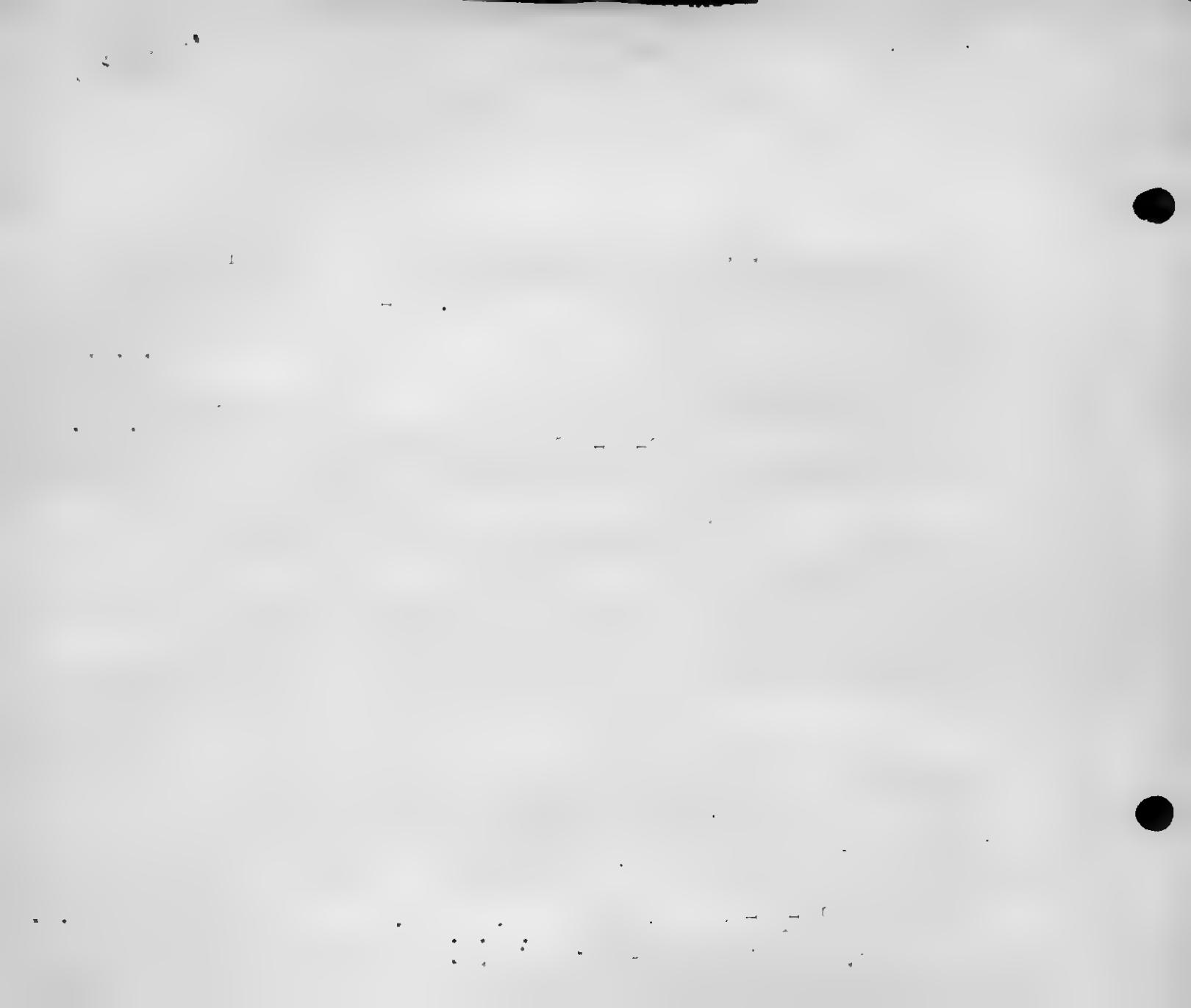
J. Collins ADDRESS WASH. D.C. REC'D BY REGISTRAR

FRANCIS J. COLLINS 382 Y 14TH. ST. N.W.

25b. REGISTRAR'S SIGNATURE

DATE DEC 13 1966

Charles Judge



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

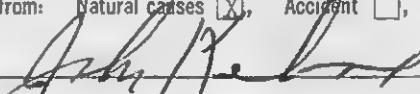
17662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17656

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DCA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4-N Laurel Hill	
3. NAME OF DECEASED (Type or print) Berrie Elizabeth		First Middle Last	4. DATE OF DEATH Month Day Year 12 4 1966
5. SEX female white		6. COLOR OR RACE WIDOWED DIVORCED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 6-6-06		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Ice cream co.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Lindsey		14. MOTHER'S MAIDEN NAME Laura Queen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579 16 0975	17. INFORMANT Paul Lorentz Greenbelt, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction and aspiration of gastric contents, and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarction of small intestine due to fibrous adhesions and linking. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 12-6-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery Arlington Virginia
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE DEC 8 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



Items 18&21 Film 385 2-MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

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17663

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17657

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c LENGTH OF STAY IN FB DOA	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	d STREET ADDRESS 5450 Newton Street, Apt. 6	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First David	Middle Lewis	Last Lugo	
4 DATE OF DEATH 12 23 19 66	Month Day Year			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED W DIVORCED	8. NEVER MARRIED D.VORCED	
9. DATE OF BIRTH 25 Sept. 1966		9. AGE (In years lost b'day) 3 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME LOUIS LUGO		14. MOTHER'S MAIDEN NAME MARGIE BOWEN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT LOUIS LUGO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO 525 X Fulmonary atelectasis		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Interstitial pneumonitis				
DUE TO SDII				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY CAUSE TIME OF INJURY Month, Day, Year Hour a.m. 19				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20c. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kohoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Riverdale, Md.		
22. DATE SIGNED 12-25-66				
23a. BURIAL, CREMATORY, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 27 Dec 1966		23c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		ADDRESS		23d. LOCATION (City or Town) WASHINGTON, D.C.
25a. DECEASED BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE O. - 12-25-66		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17664

CERTIFICATE OF DEATH

17658

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH <b>PRINCE GEORGE'S COUNTY MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND PRINCE GEORGE'S COUNTY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c LENGTH OF STAY IN lb <b>5HR 45MIN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp.to give street address) <b>USAF HOSPITAL ANDREWS</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>(NMN)</b>	Last <b>MAC DONALD</b>
4. DATE OF DEATH <b>DECEMBER 7 1966</b>	Month Year	Month Day	Year Year
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>7 DEC 66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13. FATHER'S NAME <b>JAMES JOSEPH MAC DONALD</b>		14. MOTHER'S MAIDEN NAME <b>TAKA (NMN) OGATA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>N/A N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>JAMES J MAC DONALD-FATHER-SAME AS #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>7735</b> (b) <b>PREMATURITY</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>5HR 45MIN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>USAF HOSPITAL ANDREWS</b>
20f. (City or town) <b>ANDREWS AFB, WASHINGTON DC 20331</b>		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7 DEC 1966</b> to <b>7 DEC 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7 DEC 1966</b> , and that death occurred at <b>4:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Paul G. Perlstein</b>		P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>7 DEC 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PAUL G. PERLSTEIN, CAPT, USAF, MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/12/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Frington Park</b>
24. FUNERAL DIRECTOR <b>Bill Chambers Co. 57711 STSC</b>		ADDRESS <b>ATTA CO.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
		DATE <b>DEC 12 1966</b>	25b. REGISTRAR'S SIGNATURE



1 M  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17665

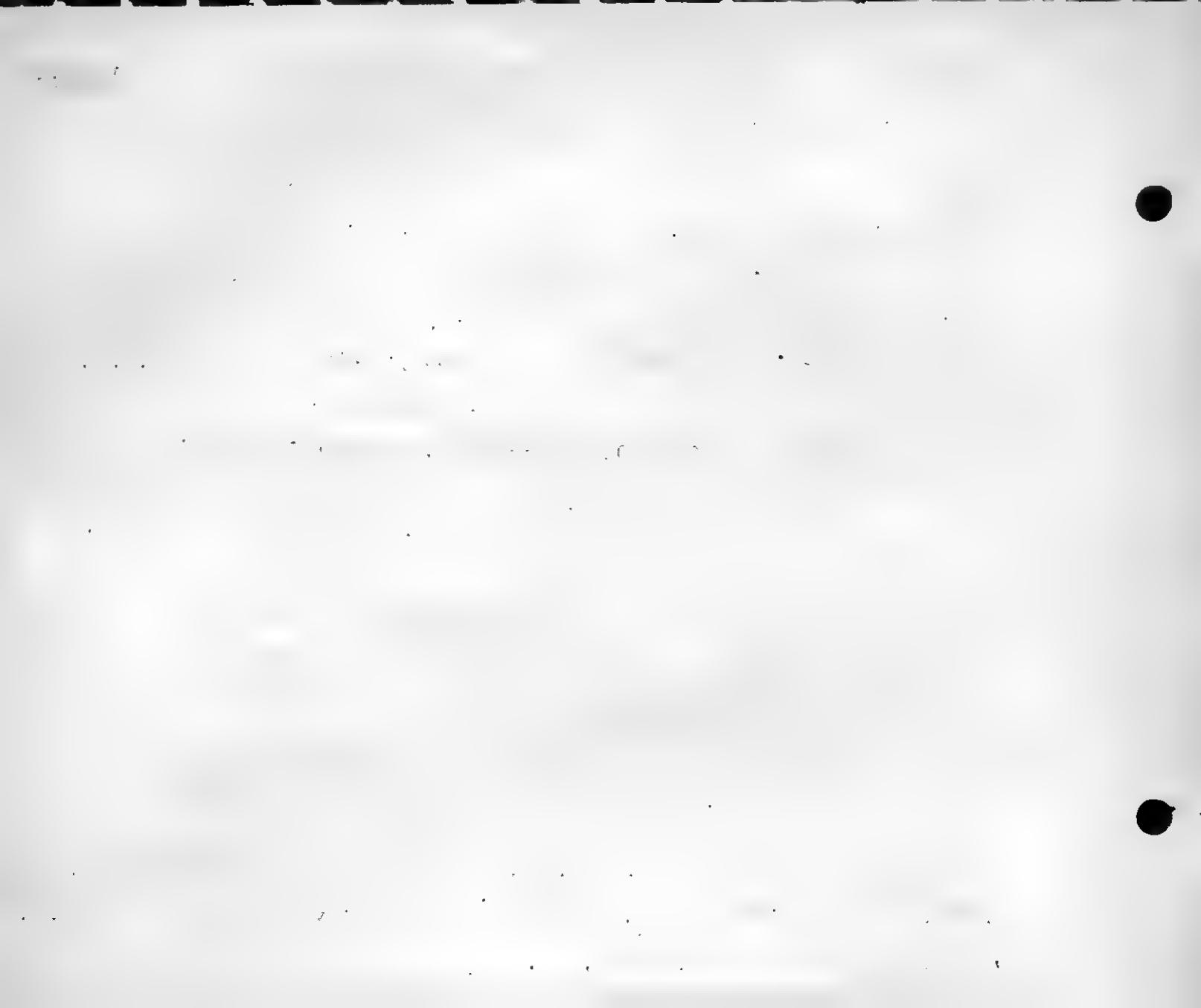
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17659

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Maryland Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DCA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7770 Hawthorne Street	
		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
Frederica Kane Maloney		12	13 19 66
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	24 Nov. 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kane		14. MOTHER'S MAIDEN NAME Marie Purcell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 100 18 0276	
no		17. INFORMANT Richard J. Calistri Same as #2	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH minutes	
Heart failure		unknown	
DUE TO Arteriosclerotic heart disease			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John Kehoe</i>			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 22. DATE SIGNED 12-13-66	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Buffalo		23b. DATE THEREOF 12/17/66	
23c. NAME OF CEMETERY OR CINERATORIUM St. James		23d. LOCATION (City, town or county) Waverly (State) N. Y.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE DEC 19 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

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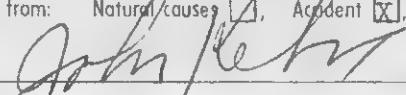
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17666

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17660

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale LENGTH OF STAY IN lb three hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 720 Dunloggan Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Fitz	Middle Hugh	Last B. Marshall, Jr.	DATE OF DEATH 12 2 1966
S. SEX male	6 COLOR OR RACE white	7. MARRIED W DOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-12	9. AGE (In years last birthday) 54 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist		10b KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) New Mexico	
13. FATHER'S NAME Fitz-Hugh B. Marshall, Sr.		14. MOTHER'S MAIDEN NAME Late Lola		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO 174-22-6548		17. INFORMANT Mrs. Genevieve Marshall Address 270 Dunloggin Rd. Ellicott City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 8164 (b) Trauma - auto accident DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) passenger in car involved in collision			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:00pm p.m. 12-2 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. #1, Beltsville, Beltsville, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John J. Kehoe M.D., Riverdale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5, 1966		23c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery	
23d. LOCAT ON (City or Town) (County) (State) Ellicott City Howard Md.		23e. REC'D BY REGISTRAR DATE		23f. REG STRAR'S SIGNATURE	
24. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pk., Ellicott City, Md.		ADDRESS			
VR A15ME 10 6M 1/66					



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17667

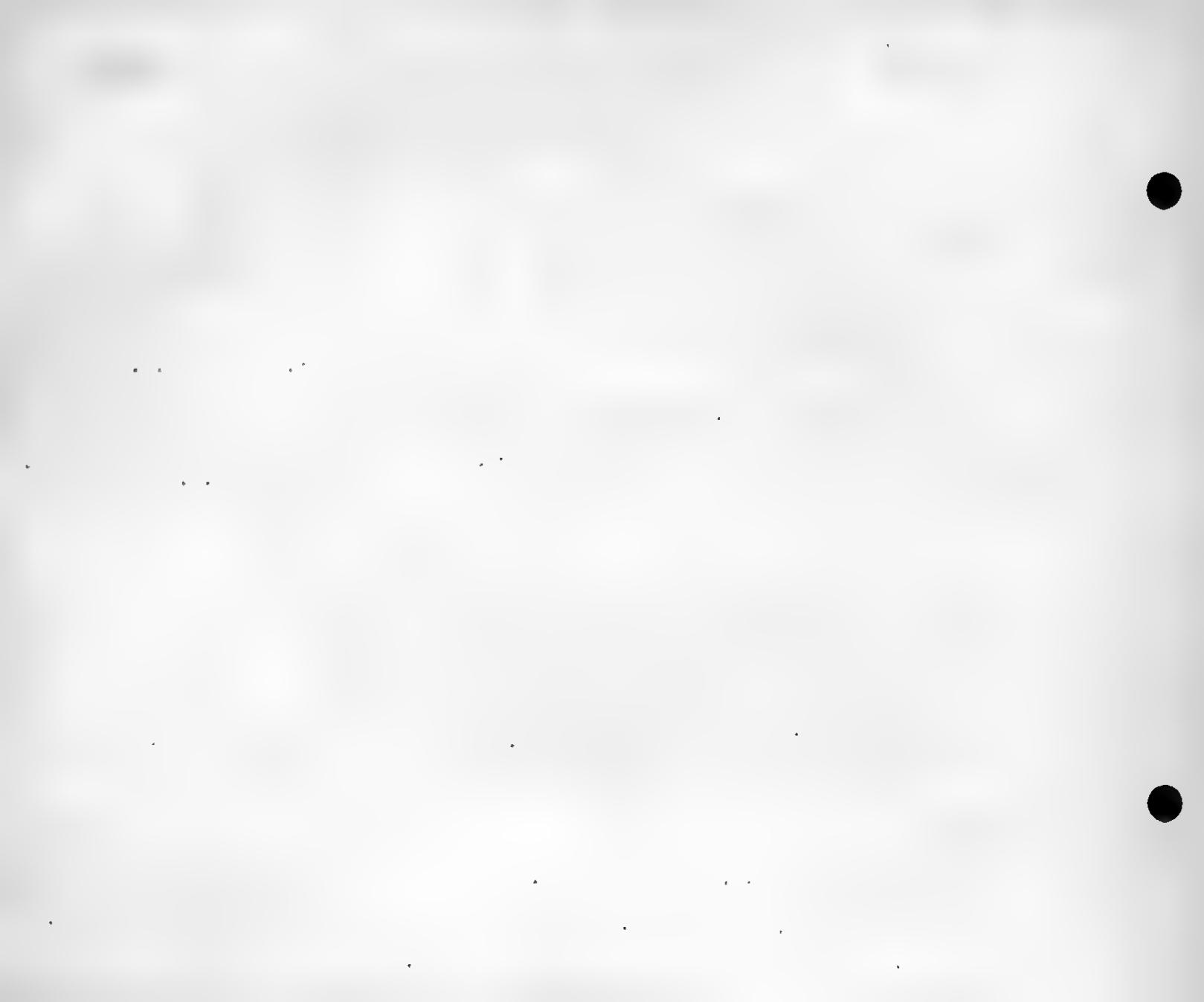
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17661

If any delay is  
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5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages (and 2) with the State Department of  
Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Howard</u>		
c LENGTH OF STAY IN MD <u>DOF.</u>			c CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Ellicott City</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Iceland Memorial Hospital</u>			d STREET ADDRESS <u>720 Dunloggin Road</u>		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)		First <u>Paul</u>	Middle <u>Norman</u>	Last <u>Marshall</u>	4 DATE OF DEATH 12 2 1966
5 COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-17</u>	9. AGE (In years last birthday) <u>19</u> YRS	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a USA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>The late Fitz-Hugh B. Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <u>no</u>		16. SOCIAL SECURITY NO <u>216-46-2023</u>	17. INFORMANT <u>Mrs. Genevieve Marshall, 720 Dunloggin Rd.</u>	Address <u>E.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>816.4</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>driver of car involved in collision</u>			
20c. TIME OF INJURY Month, Day, Year Hour am <u>6:00pm pm</u> 12-2 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>U.S. Route 1</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beltsville, Md.</u>	20f. (City or town) <u>Beltsville, Md.</u>	(County) <u>Md.</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Rehorek</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>John Rehorek A.D., Riverdale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 5, 1966</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>St. Johns Cemetery</u>	23d. LOCATION (City or Town) <u>Ellicott City</u>	(County) <u>Howard</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Harry H. Witzke, 321 Columbia Pk., Ellicott City, Md.</u>		ADDRESS <u>DEC 5 1966</u>	25a. REC'D BY REGISTRAR <u>DEC 5 1966</u>	25b. REGISTRAR'S SIGNATURE <u>John Rehorek</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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17568

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17662

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>R. George Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HYATTSVILLE NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle <b>FREDERICK</b>	Last <b>MARTIN</b>
4. DATE OF DEATH Month <b>DEC.</b> Day <b>7</b> Year <b>1966</b>	5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>AUG. 5, 1895</b>	9. AGE (In years last birthday) <b>71 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERINTENDENT (RETIRED) BAKERY</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>GEORGE MARTIN</b>	14. MOTHER'S MAIDEN NAME <b>CHRISTIANA MANNOLD</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Miss Irene E. Martin - 2104 Bananac Place</b>	Address <b>Hyattsville 100</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH</b> , 1966, to <b>DEC.</b> , 1966, that (I) (we) last saw the deceased alive on <b>DEC. 7, 1966</b> , and that death occurred at <b>2104</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard A. Fitzgerald</b>		22b. DATE SIGNED <b>12-7-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD A. FITZGERALD</b>		22d. ADDRESS <b>217 University Blvd E. - SIL SP. MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/10/1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery Silver Spring, Md.</b>	23d. LOCATION (City, town or county) (State) <b>SILVER SPRING, MD.</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS INC - Silver Spring, MD.</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 15M 4-64		DATE <b>DEC 9 1966</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17669

CERTIFICATE OF DEATH

17663

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 7/1/2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>518 Peabody St., N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Hattie</b>	Middle --	Lost <b>Matthews</b>	4. DATE OF DEATH 12 26 19 66	Month Day Year	
S SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/1880</b>	9. AGE (In years last birthday) <b>86 yrs</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a US JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown (retired)</b>		10b KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexandria Morton</b>				14. MOTHER'S MAIDEN NAME <b>Rosie Whiting</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>579-12-1251</b>		17. INFORMANT <b>D.C. General Hospital and daughter Mrs. Margaret McFadden, 908 Division Ave., N.E.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recurrent cerebrovascular accident (thrombosis)</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>33IX</b>							
DUE TO (b) <b>Cerebral arteriosclerosis</b>				unknown			
DUE TO (c) <b>Generalized arteriosclerosis</b>				unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Pulmonary tuberculosis</b>				19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/11</b> , 19 66, to <b>12/26/1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/26/1966</b> , and that death occurred at 9:00 P.M., from causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b>				22b. DATE SIGNED <b>12/26/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>			
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>12-30-66</b>		23b. DATE THEREOF <b>12-30-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Highland Park Md</b>	
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons 4925 Decatur St.</b>		ADDRESS <b>6-2</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Glenda Jules</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17670

CERTIFICATE OF DEATH

17664

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

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PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Res. before admission)	
a. COUNTY	Prince George	a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Laurel	b. COUNTY	Prince George
c. LENGTH OF STAY IN lb	Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and g.v.e nearest town)	Laurel, Maryland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	611 10th Street	d. STREET ADDRESS	611 10th Street
e. IS RESIDENCE ON A FARM?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Rose	Middle Ethel	Last Matthews
4. DATE OF DEATH	Month December	Day 1	Year 1966
5. SEX	6. COLOR OR RACE	7. MARRIED	8. NEVER MARRIED
Female	Negro	<input checked="" type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED
9. AGE (In years last birthday)	10. DATE OF B.RTH	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
48rs	March 24, 1918	Maryland	U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME	
No sewife		Preston Johnson	Amelia Harrison
14. MOTHER'S MAIDEN NAME	Address		
Kermit E. Matthews	Item #2		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
			PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)  170X  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b)	Acute Pulmonary Oedema
		DUE TO (c)	Generalized Carcinomatosis
			Adeno-carcinoma of the left breast
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from Dec. 1, 1966, and that death occurred at 9:10 A.M. causes and on the date stated above.	1955	19	10 Dec., 1966
22. SIGNATURE	22b. DATE SIGNED		
Robert C. Wingfield, MD.	Dec. 1, 1966		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town) (County) (State)
Burial	12/5/66	Baltimore National	Baltimore, Maryland
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert C. Wingfield, Rockville, Md.		DATE DEC 7 1966	Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17671

## CERTIFICATE OF DEATH

17665

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Fill in and sign page 3. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Pr. Geo.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b MARYLAND	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		d. STREET ADDRESS <b>9324 Defence Highway</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pr. Geo. Gen. Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First <b>Orrie</b>	Middle <b>Gay</b>	Last <b>Maxwell</b>
4. DATE OF DEATH Dec. 29	Month 1966	Day 19	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>8 Mar 1893</b>		9. AGE (In years last birthday) <b>73 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Essel Stewart</b>		14. MOTHER'S MAIDEN NAME <b>Cordelia Stewart Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>579 14 6963</b>	
17. INFORMANT <b>Mary L. Maxwell Wife</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cerebral thrombosis with cerebral hemorrhage</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerotic heart infarction</b> ONSET AND DEATH (c) <b>Gangrenous arteriosclerosis</b> Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Colmar Manor</b>
20f. (City or town) <b>Glen Dale, Md.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/2</b> , 19 <b>55</b> , to <b>12/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> , 19 <b>66</b> , and that death occurred at <b>5:15 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <i>H. James Kutz</i>		22b. DATE SIGNED <b>12/30/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. James Kutz</b>		22d. ADDRESS <b>Glen Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/3/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor</b> (County) <b>Maryland</b> (State)	
24. FUNERAL DIRECTOR <b>F. Fasch's Sons Hyattsville, Md.</b>		ADDRESS	
		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>John F. Fasch</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17672

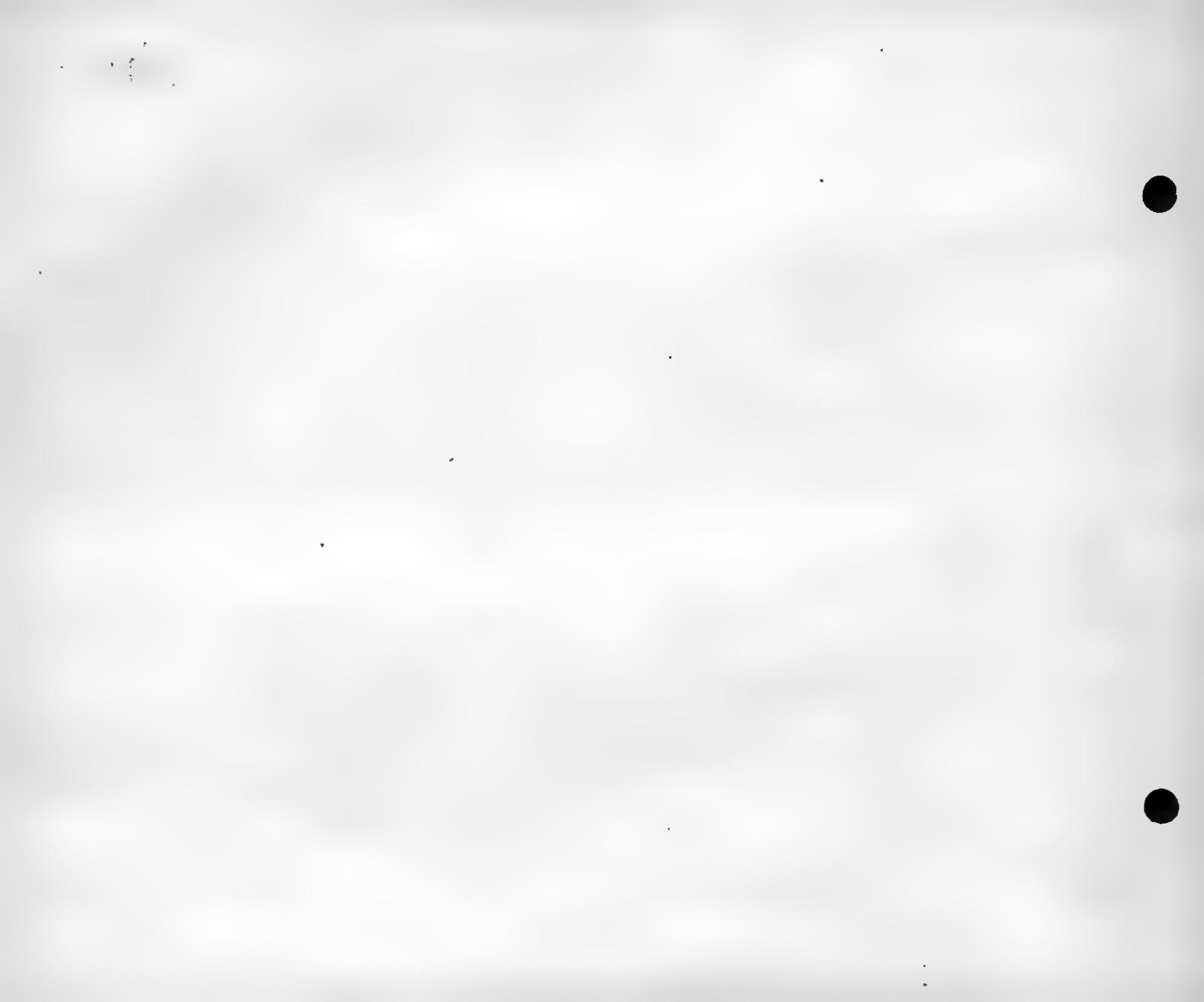
## CERTIFICATE OF DEATH

17668

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Verdant, Md.</i>		c. LENGTH OF STAY IN 1b <i>6 hrs 16 min</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Verdant, Md.</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Verdant, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eugene Island Memorial Hospital</i>		e. STREET ADDRESS <i>1718-26th Ave. (S.E. Washington)</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Caroline</i>		First <i>Caroline</i>	Middle <i></i>
4. DATE OF DEATH Month <i>December</i>	Day <i>22</i>	Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <i>1/27/40</i>	9. AGE (In years, months, days) yrs. <i>27</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. US. LOCAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Greenwald</i>	14. MOTHER'S MAIDEN NAME <i></i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i>Mrs. H.R. Trott</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
(b) DUE TO <i>Arteriosclerotic Hypertensive Cardiovascular Disease</i>		15 years	
(c) DUE TO <i>Arteriosclerosis Generalized</i>		25 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>Dec. 19 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5118-26th Ave.</i>
20f. (City or town) <i>Bethesda</i>		20g. (County) <i>Montgomery</i>	20h. (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 30, 1953</i> , to <i>Dec. 29, 1966</i> , that (I) (we) last saw the deceased alive on <i>December 28, 1966</i> , and that death occurred at <i>5118-26th Ave.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Walcutt W. Gibson</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Walcutt W. GIBSON, M.D.</i>		22d. ADDRESS <i>4300 St. Barnabas Road, Marlow Hts. Md. (via D.C. 20033)</i>	22e. DATE SIGNED <i>December 29, 1966</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 31, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Hebazon Church</i>
23d. LOCATION (City or Town) <i>West Middin, Pa.</i>		(County) <i></i>	
24. FUNERAL DIRECTOR <i>F. Joseph's Sons Hyattsville, Md.</i>		25e. ADDRESS <i></i>	25f. REC'D BY REGISTRAR DATE JAN 3 1967
		25g. REGISTRAR'S SIGNATURE <i>J. L. J. J.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17573

CERTIFICATE OF DEATH

17667

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi Md		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum Heights, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paint Branch Nursing Home			d. STREET ADDRESS 5931 15th avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Catherine	Middle Q.	Last McClintock	4. DATE OF DEATH	Month Dec 9,	Day 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 21, 1870	9. AGE (In years 95 birthday) yrs	10. UNDER 1 YEAR Months	11. UNDER 24 HRS Days Hours Min
10a. USUA. OCCUPAT. ON (Give kind of work done during most working life even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Quinton			14. MOTHER'S MAIDEN NAME Mary A. Sheehan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219 54 8292T		17. INFORMANT Address Mary L. Freysz Chillum Heights, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH 2-3 days 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> years (c) _____						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963, 19 to 12-9, 1966, that (I) (we) last saw the deceased alive on 12-7 1966, and that death occurred at 6:00 P.M. from causes and on the date stated above.						
22a. SIGNATURE <u>Donald C. Egren</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-10-66		
22c. PHYSICIAN'S NAME (Type) <u>DONALD C. EGREN</u>		22d. ADDRESS <u>Hyattsville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 12, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville, Md.		25a. RECD BY REGISTRAR DEC 15 1966	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
VR A15 (4) 20 M 1/66						



FOR STATE  
HEALTH DEPT.

17674

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17668

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b>	
d. STREET ADDRESS <b>6419 K St.,</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Ernest Eugene McConneyhead</b>		First <b>Ernest</b>	Middle <b>Eugene</b>
4. DATE OF DEATH <b>12</b>	Month <b>10</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>H N</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>
8. DATE OF BIRTH <b>5 Jan., 1966</b>	9. AGE (In years last birthday) yrs <b>11</b>	10. IF UNDER 1 YEAR Months <b>4</b>	11. F. UNDER 24 HRS Days Hours Mn <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
13. FATHER'S NAME <b>VERNON FRANKLIN</b>	14. MOTHER'S MAIDEN NAME <b>PATSY Mc CONNEYHEAD</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>PATSY Mc CONNEYHEAD</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary edema</b>
DUE TO (b) DUE TO (c)		Cause undetermined	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State)	
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Harmonie Mem. Hospital Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Harmonie Mem. Hospital Md.</b>	23b. DATE THEREOF <b>Nov 17/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmonie Mem. Hospital Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Koivins Funeral Home Inc. Hunter, D.C.</b>	ADDRESS <b>4339</b>	25a. RECEIVED BY REGISTRAR <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>James J. Magee</b>



Items 18&21 Film 387 4-13 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17675		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						17669	
1 PLACE OF DEATH a CO. /NTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Prince George's						
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB DCA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 6666 Walker Mill Road			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First James	Middle Roger	Last McDonald	4 DATE OF DEATH 12 23 19 66	Month	Doy	Year	
S SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED	NEVER MARRIED DIVORCED	B DATE OF BIRTH 29 Nov. 1966	9 AGE (In years lost birthday) 25 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min		
10 Do USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Md		12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME Raymond F Mc Donald			14. MOTHER'S MAIDEN NAME Virginia Di toto						
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) If yes give war or dates of service) no			16 SOCIAL SECURITY NO		17 INFORMANT Raymond F Mc Donald District Heights Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) S D I I 7730 Conditions, if any, wh ch gave rise to immediate cause (a). slating the underlying cause lost. DUE TO (1) DUE TO (2) Cause of death undetermined									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									19 WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) 12-25-66							
EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 3, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D C			
24. FUNERAL DIRECTOR F. Garsch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17676

## CERTIFICATE OF DEATH

17670

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4800 Berwyn House Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Bernice</b>	Middle <b></b>	4. DATE OF DEATH <b>December 17, 1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Embrey</b>		14. MOTHER'S MAIDEN NAME <b>Obera Johnson</b>	
15. IS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Lou Jean</b> 9700 51st Place College Park, Md. (sister)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diabetes Mellitus with Diabetic coma.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>260 X</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b></b>		DUE TO (b) <b>Myocardial Infarction (Papillary Muscles)</b>	
		DUE TO (c) <b>Coronary Arteriosclerotic Heart Disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>12-13</b> , 19 <b>66</b> , to <b>12-17</b> , 19 <b>66</b> , that (1) (we) lost sow the deceased alive on <b>12-17</b> , 19 <b>66</b> , and that death occurred at <b>2:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R.D.Bauer, M.D.</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-17-66</b>
22c. PHYSICIAN'S NAME (Type) <b>R.D. Bauer, M.D.</b>		22d. ADDRESS <b>2513 Buck Lodge Rd. Adelphi, Md.</b>	
23a. BURIAL, CREMATION, BONE ASH (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/20/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>Jillaries Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Jillaries Judge</b>
VR A15 (4) 20 M 1/66		DATE <b>12-22-1966</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

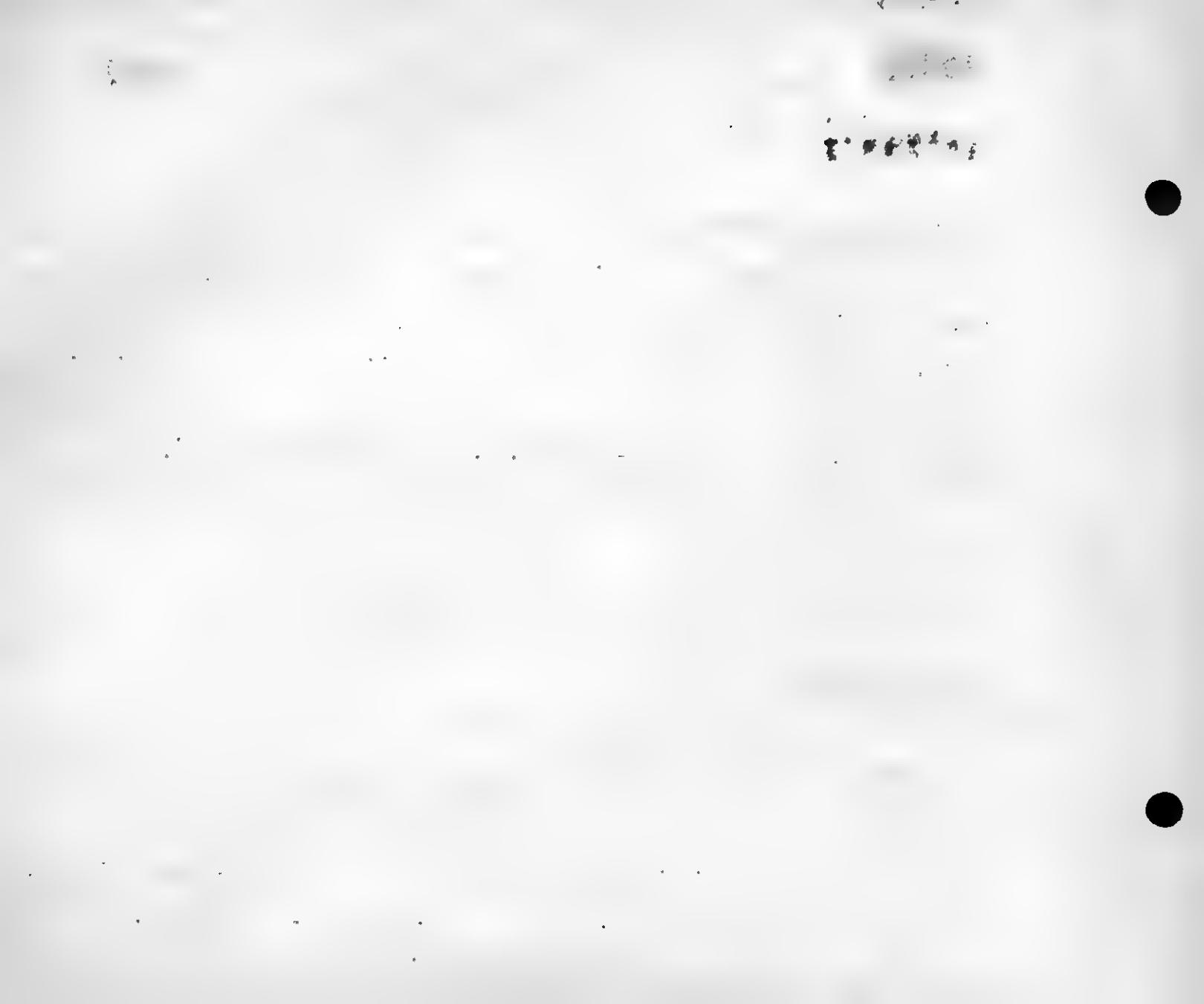
CERTIFICATE OF DEATH

17671

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Alabama				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 6 days	b. COUNTY Birmingham				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1422 Melrose Place				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Frank	Middle L.	Last Medearis			
4. DATE OF DEATH Dec., 27 19 66						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED			
9. B DATE OF BIRTH 6 June 1885		9. AGE (in years lost birthday) 81 yrs				
10. INDUSTRIAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) Lincoln Co. Tennessee				
12. CITIZEN OF WHAT COUNTRY U.S.A.						
13. FATHER'S NAME Washington Davis Medearis		14. MOTHER'S MAIDEN NAME Lucy Allen				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. I		16. SOCIAL SECURITY NO 409-54-1694				
17. INFORMANT Wm. D. Medearis, Hyattsville, Md.		3223 Toledo Pl.				
18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						
INTERVAL BETWEEN ONSET AND DEATH						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Colmar Manor</i>	20f. (City or town) <i>Hyattsville</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>12/21/66</i> to <i>12/26/66</i> , that (I) (we) last saw the deceased alive on <i>12/25/66</i> , and that death occurred at <i>12:50 P.M.</i> from causes and on the date stated above.				22b. DATE SIGNED 12/27/66		
22c. SIGNATURE <i>Aaron Deitz, M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS Prince George's Plaza, Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 28, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory	23d. LOCATION (City or Town) Colmar Manor, Md.		
24. FUNERAL DIRECTOR F, Gasch's Sons 4739, Balt. Ave. Hyattsville, Md.		ADDRESS <i>4739 Balt. Ave. Hyattsville, Md.</i>	25a. RECD BY REGISTRAR DATE <i>DEC 27 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Aaron Deitz, M.D.</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17578

CERTIFICATE OF DEATH

17672

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>		c. LENGTH OF STAY IN 1b <b>SUITLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2216 LAKEWOOD STREET</b>		e. STREET ADDRESS <b>2216 LAKEWOOD STREET</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>KX</b>			
3. NAME OF DECEASED (Type or print)	First <b>CATHERINE</b>	Middle <b>C.</b>	Last <b>MERCHANT</b>
4. DATE OF DEATH	Month <b>DECEMBER</b>	Day <b>16</b>	Year <b>1966</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>MARCH 18, 1883</b>	9. AGE (In years last birthday) <b>83 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM WINDSOR</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>215 56 9234</b>	17. INFORMANT <b>OLIN L. MERCHANT</b>
		Address <b>SEAT PLEASANT MD 9307 WELLINGTON ST.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>502x</b> (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>5 years</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HA</b>
20f. (City or town) <b>HA</b>		(County) <b>MD</b>	
		(State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5-31-1961</b> to <b>12-16-1966</b> , that (I) (we) last saw the deceased alive on <b>12-15-1966</b> , and that death occurred at <b>HA</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David L. Gordon, MD</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-16-66</b>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/19/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>CEDAR HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGES, MARYLAND</b>
24. FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
		DATE <b>DEC 22 1966</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)											
a. COUNTY <b>Prince George's</b> MARYLAND				b. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>3813 40th Avenue</b>											
3. NAME OF DECEASED (Type or print) <b>Everett Gilbert Miller</b>				First		Middle		Lost		4. DATE OF DEATH 12 20 1966	Month Year				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED W DIVORCED <input type="checkbox"/>		8. NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH <b>29 April 1915</b>		9. AGE (In years last birthday) <b>51</b> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Central Co</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Albert Miller</b>				14. MOTHER'S MAIDEN NAME <b>Jessie Alma Dearing</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>224 14 5347</b>				17. INFORMANT <b>Kenneth Miller</b>				Address <b>Seat Pleasant, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subdural hematoma</b> DUE TO <b>Fracture of skull</b> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>undetermined</b>							
				20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>unknown unknown</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, or building, etc.) <b>unknown</b>		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22. DATE SIGNED <b>12-22-66</b>			
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				Address (Street, city, town, or county) <b>Riverdale, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>									
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <i>John Kehoe</i>							
VR A15ME (5) 6M 1/67															

100



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17680

## CERTIFICATE OF DEATH

17674

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN b. <i>19 months</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>6700 Belcrest Road</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				
d. STREET ADDRESS <i>6700 Belcrest Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Harry</i>	Middle <i>Curtis</i>	Last <i>Minier</i>	4. DATE OF DEATH Month <i>December</i>	Day <i>14</i>	Year <i>1966</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov. 16, 1889</i>	9. AGE (In years last birthday) yrs <i>77</i>	IF UNDER 1 YEAR Months <i>0</i>	F. UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>G.P.O. U.S. Govt.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Townsend Minier</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Ort</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>579-52-6622</i>		17. INFORMANT <i>Mrs. Margaret Minier</i>		Address <i>6700 Belcrest Rd. Hyattsville, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Myocardial infarction</i>								
DUE TO (b) <i>Myocardial infarction</i>								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <i>Arteriosclerosis</i>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Dec. 17, 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Fort Lincoln Cemetery</i>		20f. (City or town) <i>Prince Georges Co., Md.</i>	(County) <i>Prince Georges Co., Md.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 16, 1941</i> to <i>Dec. 17, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 16, 1966</i> , and that death occurred at <i>7:30 AM</i> , from causes and on the date stated above.								
22a. SIGNATURE <i>Charles U. Pate</i>				22b. DATE SIGNED <i>12-14-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>Charles U. Pate</i>		22d. ADDRESS <i>3335 Jennyson St., N.W.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 17, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Prince Georges Co., Md.</i>		
24. FUNERAL DIRECTOR <i>John B. Thomas Garner E. Lumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D. BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20 M 1/66		DATE DEC 10 1966						



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17681

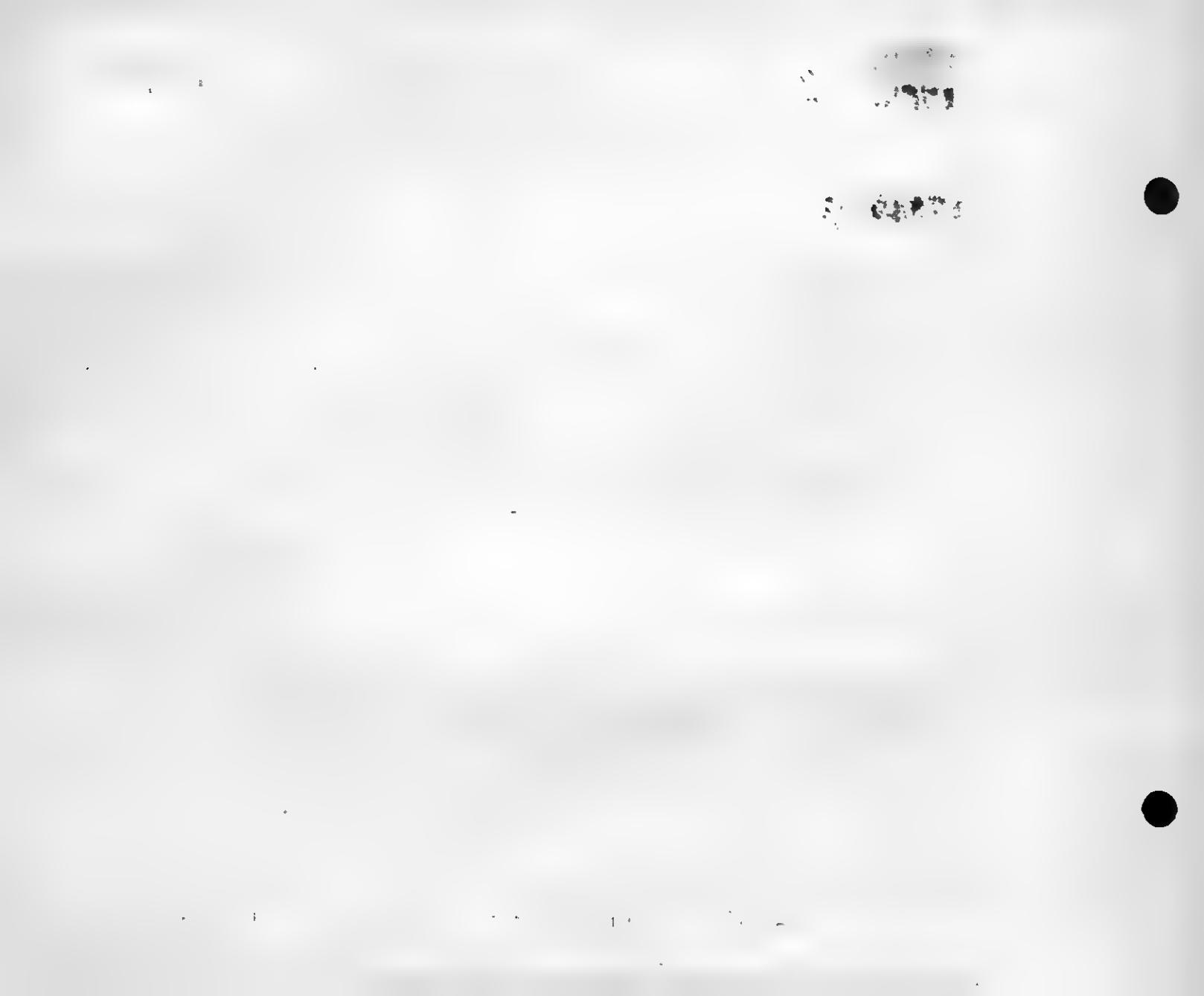
## CERTIFICATE OF DEATH

17675

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, air removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN lb 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT BELVOIR	
3. NAME OF DECEASED (Type or print) MARCIA		First CELESTE	Middle MOORE
4. DATE OF DEATH DECEMBER	Month 8	Day 19	Year 66
5. SEX FEMALE	6. COLOR OR RACE NEGROID	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH 21 MAY 1962	9. AGE (In years last birthday) 4 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUA. OCCUPATION (Give kind of work done during most of work life, even if retired) N/A	10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.	
13. FATHER'S NAME FEINSTER MILES MOORE JR		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME BERNICE LUZETTA TRUESDALE		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO N/A	17. INFORMANT FEINSTER M. MOORE JR-FATHER-SAME AS #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>22.6</u>			
DUE TO (b) <u>SICKLE CELL ANEMIA &amp; CEREBRAL HEMORRHAGE</u>			
DUE TO (c) <u>OVERWHELMING SEPSIS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>25 NOV</u> , 19 <u>66</u> , to <u>8 DEC</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8 DEC</u> , 19 <u>66</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Roger L. Spitzer, Jr.</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8 DEC 66
22c. PHYSICIAN'S NAME (Type) ROGER L. SPITZER, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-13-66	23b. DATE THEREOF 12-13-66	23c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR <u>John T. Rhiney 3015-12 st NE</u>	ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 15 1966	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**17682**

**CERTIFICATE OF DEATH**

**17676**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or during transit, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boulevard Heights</b>		c. LENGTH OF STAY IN 1b <b>5 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>4808 Boulevard Heights</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boulevard Heights</b>	
f. STREET ADDRESS <b>4808 Alton Street S.E.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First Martha E. Middle</b>		4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED WIDOWED <input type="checkbox"/>		8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>Dec 30, 1896</b>		10. AGE (In years at birthday) <b>69 yrs</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Beck</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Marshall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Nellie Marsden</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>420.10</b> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> INTERVA. BETWEEN ONSET AND DEATH <b>2-3 years</b>	
19. MEDICAL CERTIFICATION		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
22. I certify that (I) (this hospital) attended the deceased from <b>15 Nov 1966</b> , to <b>25 Dec 1966</b> , that (I) (we) last saw the deceased alive on <b>27 Dec 1966</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>27 Dec '66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James B. Moffett</b>		22d. ADDRESS <b>1125 Rockville Pike Rockville Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rental</b>		23b. DATE THEREOF <b>12/30/1966</b>	
24. FUNERAL DIRECTOR <b>Robert M. Mattingly</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Robert M. Mattingly 131-112828 Washington</b>	
25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John J. ...</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17683

## CERTIFICATE OF DEATH

17677

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12/26/66 Dr. Kehoe notified &amp; approved.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) Landover Hills		c. LENGTH OF STAY IN lb 18 years c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3905 72nd avenue		d. STREET ADDRESS 3905 72nd avenue, . e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THURSTON ROBERT Middle MORRIS Last		4. DATE OF DEATH Month December Day 19, 1966 Year 66	
S. SEX male	6. CO. OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1918 9. AGE (In years last birthday) 48 yrs IF UNDER 1 YEAR Months Days Hours Min
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Truck	
11. BIRTHPLACE (County & State, or foreign country) Culpeper Co Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Morris		14. MOTHER'S MAIDEN NAME Annie Sherman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service yes W W 11		16. SOCIAL SECURITY NO 577 38 6140 17. INFORMANT Sarah S Morris Landover Hills, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>CORONARY OCCLUSION</i> INTERVAL BETWEEN ONSET AND DEATH SECONDS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Arteriosclerotic Heart Disease</i> (c)		5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>3 previous myocardial infarctions</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jun</i> , 1966, to <i>Dec 19, 1966</i> that (I) (we) last saw the deceased alive on <i>10 Dec 1966</i> and that death occurred at <i>11:45PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Thomas J. Malone</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>19 Dec 66</i>
22c. PHYSICIAN'S NAME (Type) <i>THOMAS J. MALONE MD</i>		22d. ADDRESS <i>4814-71st Ave. Hyattsville MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE DEC 23 1966
			25b. REGISTRAR'S SIGNATURE <i>206-18-1966</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17684

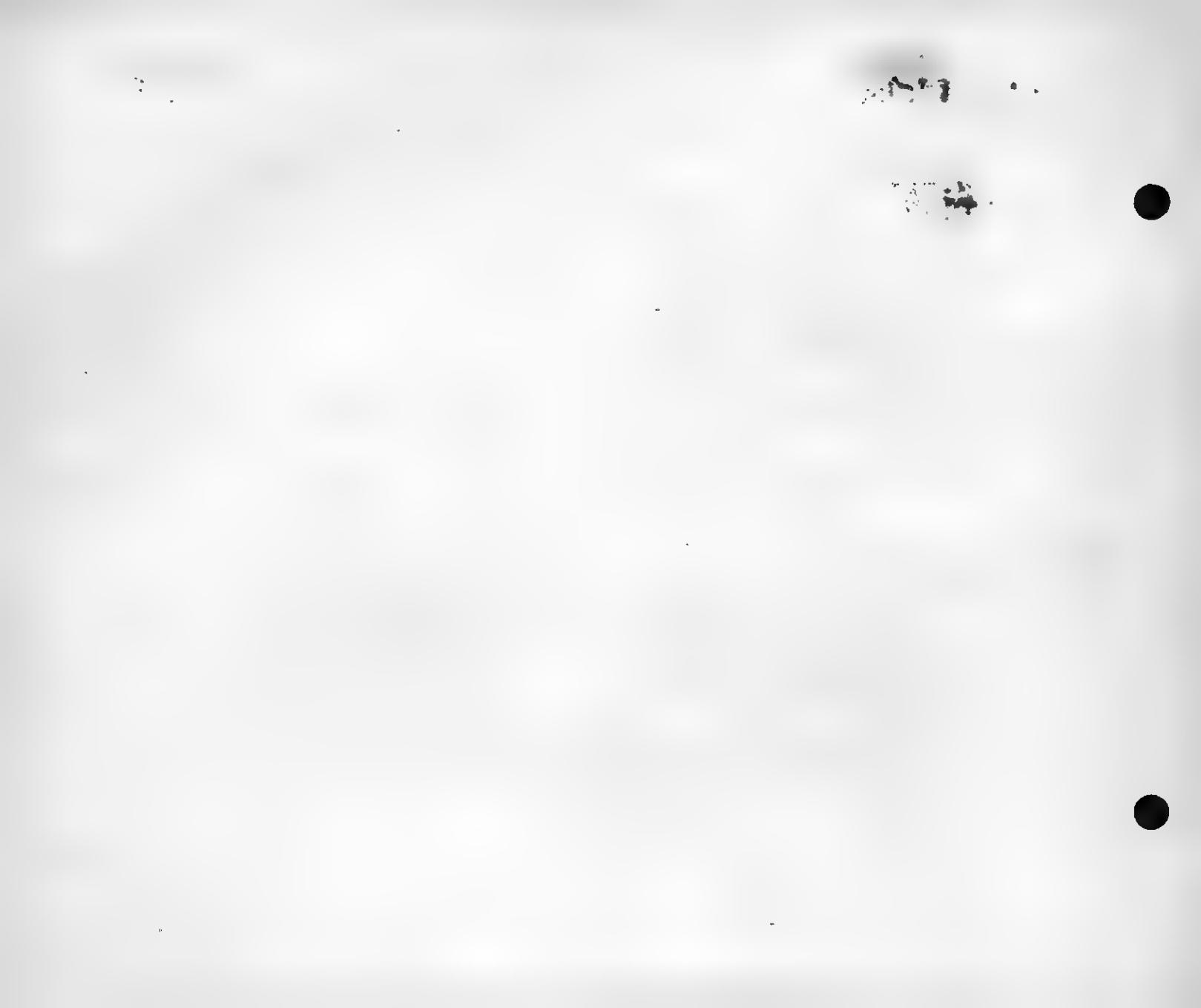
CERTIFICATE OF DEATH

17678

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or at any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>D.C. Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write R.R.# and give nearest town) <b>Forrestsville</b>		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write R.R.# and give nearest town) <b>Regent Nursing Home</b>	
		c. LENGTH OF STAY IN lb d. STREET ADDRESS <b>5006 N St. S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ida</b>	Middle <b>E.</b>	Last <b>Mountcastle</b>
4. DATE OF DEATH <b>12</b>	Month <b>12</b>	Day <b>3</b>	Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7-3-1882</b>	9. AGE (In years last birthday) <b>84 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Penn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Edmond Nelven</b>	14. MOTHER'S MAIDEN NAME <b>Emma Schulke</b>	Address <b>Edwin H. Mountcastle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) Diseases Debilitated condition of Lymphatic Leukemia		Pennsylvanian Heart Failure	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>In age cerebral fracture - lymphomatosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-2-1966</b> , to <b>11-3-1966</b> , that (I) (we) last saw the deceased alive on <b>10-2-1966</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>11-3-66</b>	
22a. SIGNATURE <b>C. E. H. - Regent MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Lee Funeral Home</b>		22d. ADDRESS <b>7200 Marlboro Place Street Hyattsville, Md.</b>	22e. REC'D BY REGISTRAR <b>Charles Judge</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-6-66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>	ADDRESS <b>Washington, D.C.</b>	25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

17680

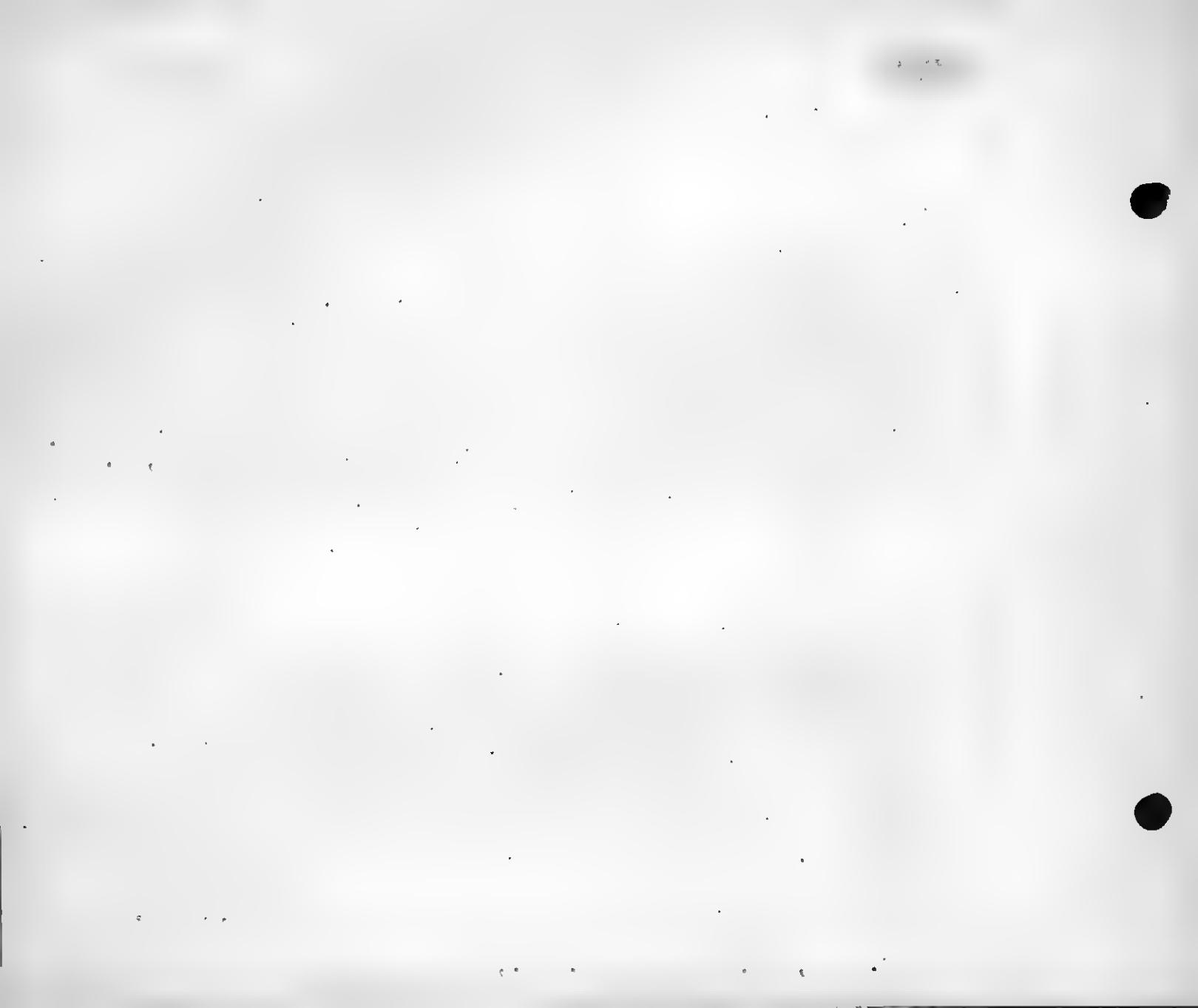
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

100  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17685		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY		a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1B		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM?			
3. NAME OF DECEASED (Type or print)		First	Middle
4. DATE OF DEATH		Month	Day Year
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2YRS	
Cconditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		ESSENTIAL HYPERTENSION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from SEPT 16, 1966, to DEC 12, 1966, that (I) (we) last saw the deceased alive on DEC 16, 1966, and that death occurred at 1015A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial 12/19/66		23c. NAME OF CEMETERY OR CREMATORIUM	
24. FUNERAL DIRECTOR		23d. LOCATION (City, town or county) (State)	
James T. Ryan, Inc.		Cedar Hill Cemetery Suitland, Maryland	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
317 Pa. Ave., SE DC DATE DEC 21 1966		1966 Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17686

## CERTIFICATE OF DEATH

17681

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7441 KEYSTONE LANE		d. STREET ADDRESS 7441 KEYSTONE LANE		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First HULDA C.	Middle NEWHOUSE	4. DATE OF DEATH DECEMBER 4 1966	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DEC. 12, 1897	
9. AGE (in years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State or foreign country) PENNSYLVANIA		
13. FATHER'S NAME WILLIAM REED		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 173-18-6068		
17. INFORMANT Mary A. Reed 7441 Keystone Lane		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  (b)  (c)		INTERVAL BETWEEN ONSET AND DEATH  Due To  Rectal Carcinoma c Metastases  Pulmonary Edema		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-4-66, 19 to 12-4, 1966, that (I) (we) last saw the deceased alive on 12-4-1966, and that death occurred at 12 PM, from causes and on the date stated above.				
22o. SIGNATURE John F. Shay		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) JOHN F. SHAY		22d. ADDRESS 5509 Old Silver Hill Rd, Suitland Md		
23o. BURIAL, CREMATION, BURNDAY (Specify) BURIAL		23b. DATE THEREOF DEC. 8, 1966	23c. NAME OF CEMETERY OR CREMATORIUM BLAIRSVILLE CEMETERY	23d. LOCATION (City or Town) (County) (State) BLAIRSVILLE, PENNSYLVANIA
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge
				25b. REGISTRAR'S SIGNATURE



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

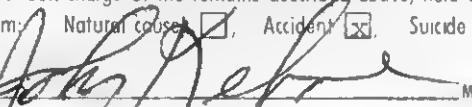
17687

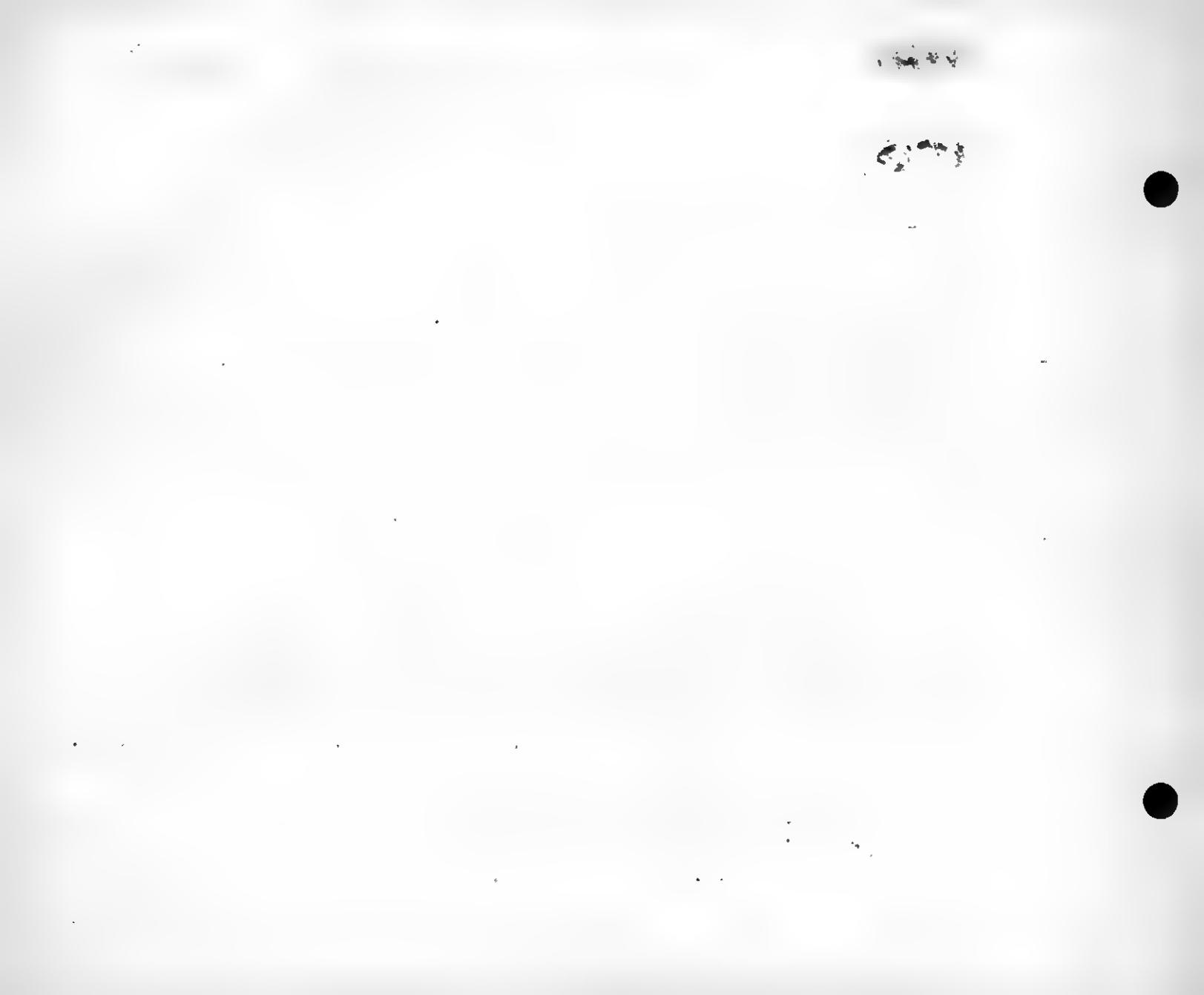
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17682

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA	c. LENGTH OF STAY IN Tb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital	d. STREET ADDRESS RFD. 1, Box 258	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Allen Nimmo	First Middle	4. DATE OF DEATH 12 11 1966	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Oct. 1922
9. AGE (In years lost birthday) yrs. 44	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Master Sgt Retired	10b. KIND OF BUSINESS OR INDUSTRY U. S. Army	11. BIRTHPLACE (State or foreign country) Capital Heights, Md.	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME William Allen Nimmo	14. MOTHER'S MAIDEN NAME Mary Elizabeth Osborne	Address 5305 Taussig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes	16. SOCIAL SECURITY NO	17. INFORMANT Melvin M. Mueller	Bladensburg Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>816.4</u> (b) DUE TO Trauma - auto accident (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in collision.	
20c. TIME OF INJURY Month, Day, Year Hour & min. 10:58pm 12-11-1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.) Rt. 3 north of Rt. 50, Kitchelville, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 12-13-66	
22. DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		23. DATE THEREOF 12/15/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fort Lincoln Cemetery Wash., D.C.	
24. FUNERAL DIRECTOR Gilbert C. Vincent 2525 Bladensburg Rd.,		23d. LOCATION (City or Town) (County) (State) Prince Georges, Md.	
VR ATSMC (5) 6M 1/66		25b. REGISTRAR'S SIGNATURE Charles Judge	



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial transcript. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

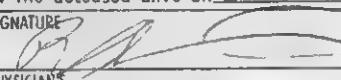
17683

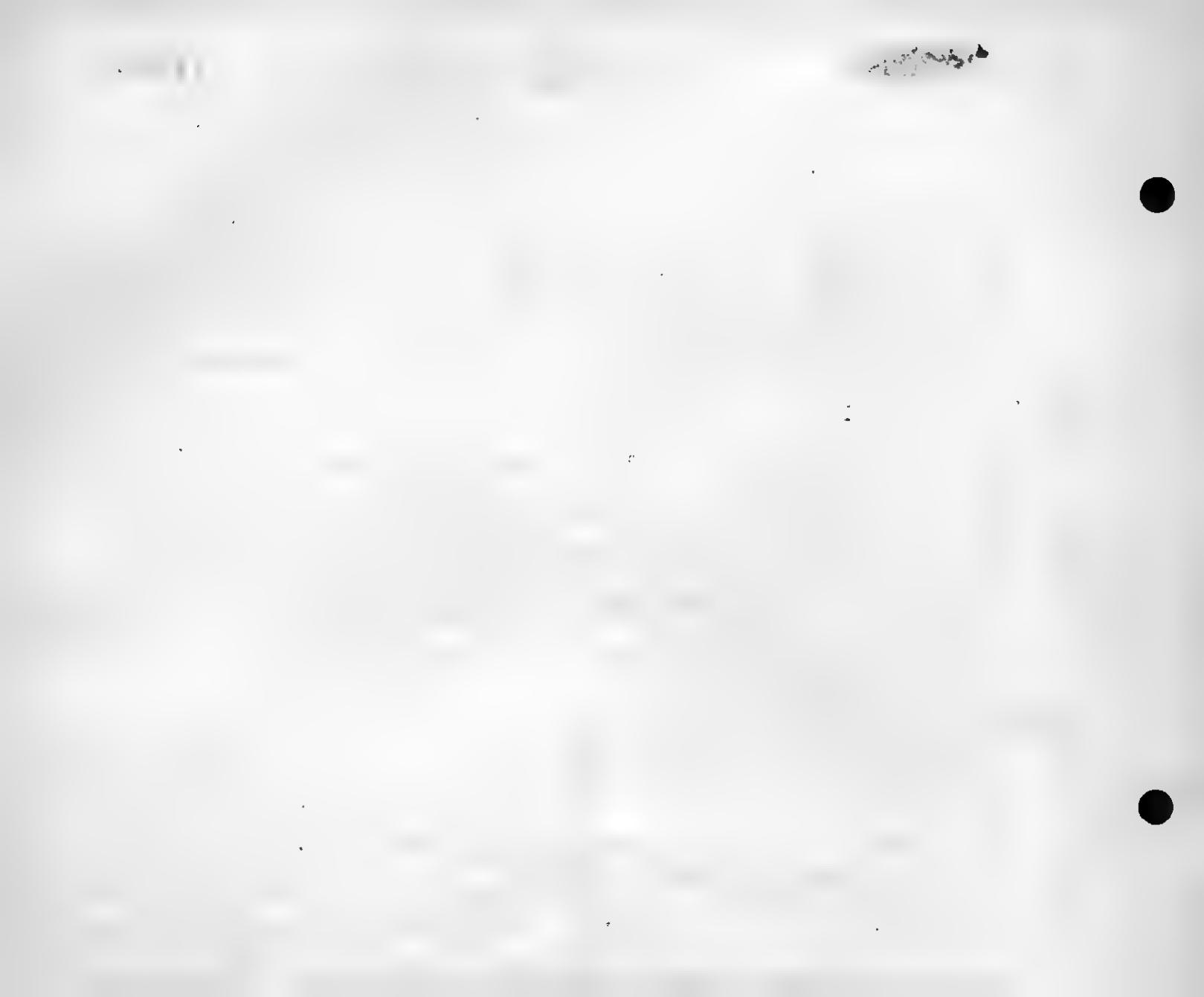
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>4206 48th Street</b>		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Henry L. Olden</b>		First	Middle	Last	4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1966</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>April 35, 1921</b>	9. AGE (in years last birthday) <b>35 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>hemothorax, right, (2500 ml.)</b>			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO <b>18IX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) <b>Perforating gunshot wound of right lung</b>					
DUE TO (c) <b>Penetrating gunshot wound of right chest</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>shot during an argument</b>			
20c. TIME OF INJURY Month Day Year Hour am <b>2:40pm pm</b> 12-1 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b>street</b>	
20f. (City or town) <b>Bladensburg, Md.</b>		(County) <b>Calvert Co.</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Lehoel</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Lehoel L.D., Riverdale, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Address (Street, city, town, or county)					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12-1-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Hallimay</b>	
23d. LOCATION (City or Town) <b>Bladensburg, Md.</b>		(County) <b>Calvert Co.</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>E.R. Lehoel</b>		ADDRESS <b>913 Flagg Rd.</b>		25a. REC'D BY REGISTRAR <b>DEC 22 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Lehoel</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
17689				CERTIFICATE OF DEATH				17684									
Items 8,9 Film 354 1/4 mi				Items 11,230 Film 104 1/2 mi													
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE CALIFORNIA b. COUNTY LOS ANGELES													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN lb 2 DAYS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOS ANGELES									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 426 SOUTH HILL STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First EDDIE		Middle HUGH		Last O'NEILL		4. DATE OF DEATH DECEMBER 14 1966		Month Day Year							
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED WIDOWED		8. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 1890 16 NOV 1892		10. AGE (In years last birthday) 76 74 yrs							
10a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) HOTEL MANAGER				10b. KIND OF BUSINESS OR INDUSTRY HOTEL				11. BIRTHPLACE (County & State, or foreign country) Hartford, Vt.		12. CITIZEN OF WHAT COUNTRY? WHITE RIVER JUNCTION, VT. U.S.A.							
13. FATHER'S NAME HUGH O'NEILL				14. MOTHER'S MÄDEN NAME ELIZABETH RENEHAN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1918-1919				16. SOCIAL SECURITY NO. 561-16-7333		17. INFORMANT OFFICIAL VETERANS ADMINISTRATION		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT				RECORDS				INTERVAL BETWEEN ONSET AND DEATH									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. T201				(b) ASHD WITH MYOCARDIAL INFARCT													
DUE TO (c)																	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)													
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 DEC 1966 to 14 DEC 1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 DEC 1966, and that death occurred at 9:15 M, from causes and on the date stated above.																	
22a. SIGNATURE 				P.M.				22b. DATE SIGNED 14 DEC 1966									
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331													
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment 12-19-66				23b. DATE THEREOF 12-19-66				23c. NAME OF CEMETERY OR CREMATORIUM Lilyfield Cemetery									
24. FUNERAL DIRECTOR W.W. Chambers Co. 517-16-8452 whole QC				ADDRESS				25a. REC'D BY REGISTRAR DATE DEC 19 1966									
								25b. REGISTRAR'S SIGNATURE Charles Judge									



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17690

CERTIFICATE OF DEATH

17685

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN lb 60 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANASSAS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			d. STREET ADDRESS 640 SUDLEY ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First LOUISE	Middle EDNA	4. DATE OF DEATH Month DECEMBER 18 19 66	Doy	Year
S SEX FEMALE	6 COLOR OR RACE CAUCASIAN	7 MARRIED WIDOWED	8 DATE OF BIRTH 9 APR 1915	9 AGE (In years last birthday) 51 yrs	10 UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDSTRY N/A		
11. BIRTHPLACE (County & State, or foreign country) STAUNTON, VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME BERNARD HUNTER PATTON			14. MOTHER'S MAIDEN NAME JULIA PICKRELL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N/A		16. SOCIAL SECURITY NO 578-09-1920		17. INFORMANT Address JUDITH B CONNER-NIECE-SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC OVARIAN CARCINOMA, WIDESPREAD</u> 2 YEARS DUE TO (c) <u>BILATERAL OVARIAN CARCINOMA</u> 2 YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) USAF Hospital Andrews	(County) (State)
21. I certify that <input checked="" type="checkbox"/> (in this hospital) attended the deceased from 19 OCT 1966, to 18 DEC 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 DEC 1966, and that death occurred at 10:15 A.M. from causes and on the date stated above.					
22a. SIGNATURE <i>Richard D. Hasz</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> 10:15 A.M. STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED DIRECTOR <input type="checkbox"/> 18 DEC 66			
22c. PHYSICIAN'S NAME (Type) RICHARD D HASZ, CAPT, USAF, MC		22d. ADDRESS Andrews AFB, Washington DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE THEREOF 12/22/66	23c. NAME OF CEMETERY OR CREMATORIAL Burlington Nat'l	23d. LOCATION (City or Town) Burlington, VA (County) (State)		
24. FUNERAL DIRECTOR W.L. Chambers 513 11 57 Se	ADDRESS W.A.T.C. 100	25a. RECEIVED BY REGISTRAR LNU 2 1966	25b. REGISTRAR'S SIGNATURE LNU 2 1966		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**17691**

**CERTIFICATE OF DEATH**

**17686**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY      Prince Georges      MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE      D.C.      b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital			d. STREET ADDRESS 3601 Connecticut Ave., N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Omer		First      Middle H.	4. DATE OF DEATH Otto      December      20, 1966	Month Year	Day	Year	
S SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/21/1906	9. AGE (In years last birthday) 60 yrs.	10. UNDER 1 YEAR Months      Days      Hours      Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grisby Otto			14. MOTHER'S MAIDEN NAME Pearl Cox			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT decedent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u>			INTERVAL BETWEEN ONSET AND DEATH sudden				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <u>phlebothrombosis, leg veins</u>		unknown			
		(c) <u>respiratory insufficiency due to marked pulmonary fibrosis and emphysema</u>		unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County)      (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/16/1966</u> , to <u>12/20/1966</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12/20/1966</u> , and that death occurred at <u>1:45 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>		M.D.      ATTENDING PHYS <input type="checkbox"/>		M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/20/66</u>	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-1966		23c. NAME OF CEMETERY OR CREMATORIUM New London Cemetery		23d. LOCATION (City or Town) Shadyside, Ohio (County)      (State)	
24. FUNERAL DIRECTOR Nalley Funeral Home Inc Rainier, Md		ADDRESS 3200 R. I. Ave.		25a. ICD BY REGISTRAR OATE		25b. REGISTRAR'S SIGNATURE <i>age</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 1d, 9 Fm 6384 1/1/67 mn

17692

## CERTIFICATE OF DEATH

17687

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Pr. Georges</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>P.R. Seco.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHINTON</i>		c. LENGTH OF STAY IN lb. <i>15 min.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Southern Md. General Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rte BX 513 - PARKER'S LANE CHINTON, MD</i>	
3 NAME OF DECEASED (Type or print) <i>JAMES</i>		First <i>J</i>	Middle <i>A</i>
4. DATE OF DEATH Month <i>DEC</i>	Month <i>28</i>	Day <i>1966</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>Dec 30 1907</i>
10a. US. JAL OCCUPATION (G ve kind of work done during most of working life, even if retired) <i>Porter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James B. Owens</i>		14. MOTHER'S MAIDEN NAME <i>Whittie C. Thompson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes WW II</i>		16. SOCIAL SECURITY NO <i>579-03-2570</i>	
17. INFORMANT <i>Madame Romel Hollis and Son</i>		Address <i>None</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  (b)  (c)		INTERVAL BETWEEN ONSET AND DEATH <i>45 min.</i>	
acute Pulmonary edema acute Myocardial Infarction		45 min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
20e. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>None</i>		20f. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20g. TIME OF INJURY Month, Day Year Hour, Min. AM/PM <i>Nov 20 1966</i>		20h. INJURY OCCURRED While Not Working at work <i>None</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) (State) <i>None</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 28 1966</i> to <i>present</i> , that (I) (we) last saw the deceased alive on <i>Dec 28 1966</i> and that death occurred at <i>6:30 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Arthur Shaver Jr.</i>		22b. DATE SIGNED <i>12/28/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>ARTHUR SHAVER JR.</i>		22d. ADDRESS <i>8808 BRANCH AVE - CHINTON, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/2/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l Fox Mayes, Va</i>
24. FUNERAL DIRECTOR <i>Robert O' Maitlingly</i>		23d. LOCATION (City or Town) <i>DATE</i>	(County) (State) <i>JAN 3 1967</i>
24b. ADDRESS <i>181-117th St. Wash DC</i>		25b. REC'D BY REGISTRAR <i>JAN 3 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Les Judge</i>



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17693

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17685

1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
a. COUNTY <b>Prince George's</b> MARYLAND		a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>101 Balsam Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Luther Samuel Palmer Sr.</b>		First <b>Luther</b>	Middle <b>Samuel</b>
4 DATE OF DEATH Month <b>12</b>	Month <b>Year 23 1966</b>	5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>8-31-20</b>	9. AGE (In years last birthday) <b>46 yrs</b>	10. IF UNDER 1 YEAR Months <b>Days</b>
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <b>Office Clerk Johnsons Transfer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Alexandria, Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>Alexandria, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Crawford Palmer</b>		14. MOTHER'S MAIDEN NAME <b>Lelia Elam</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>W.W. 2</b>		16. SOCIAL SECURITY NO <b>230-09-2120</b>	17. INFORMANT <b>Luther S. Palmer Jr.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) Arteriosclerotic Heart Disease</b> DUE TO <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm <b>19</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not While at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.) <b>(City or town) (County) (State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Check one) <b>Burial</b>	23b. DATE THEREOF <b>12/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery, Arlington Co., Va.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Everly-Wheatley Funeral Home, Alexandria, Va.</b>	ADDRESS <b>Alexandria, Va.</b>	25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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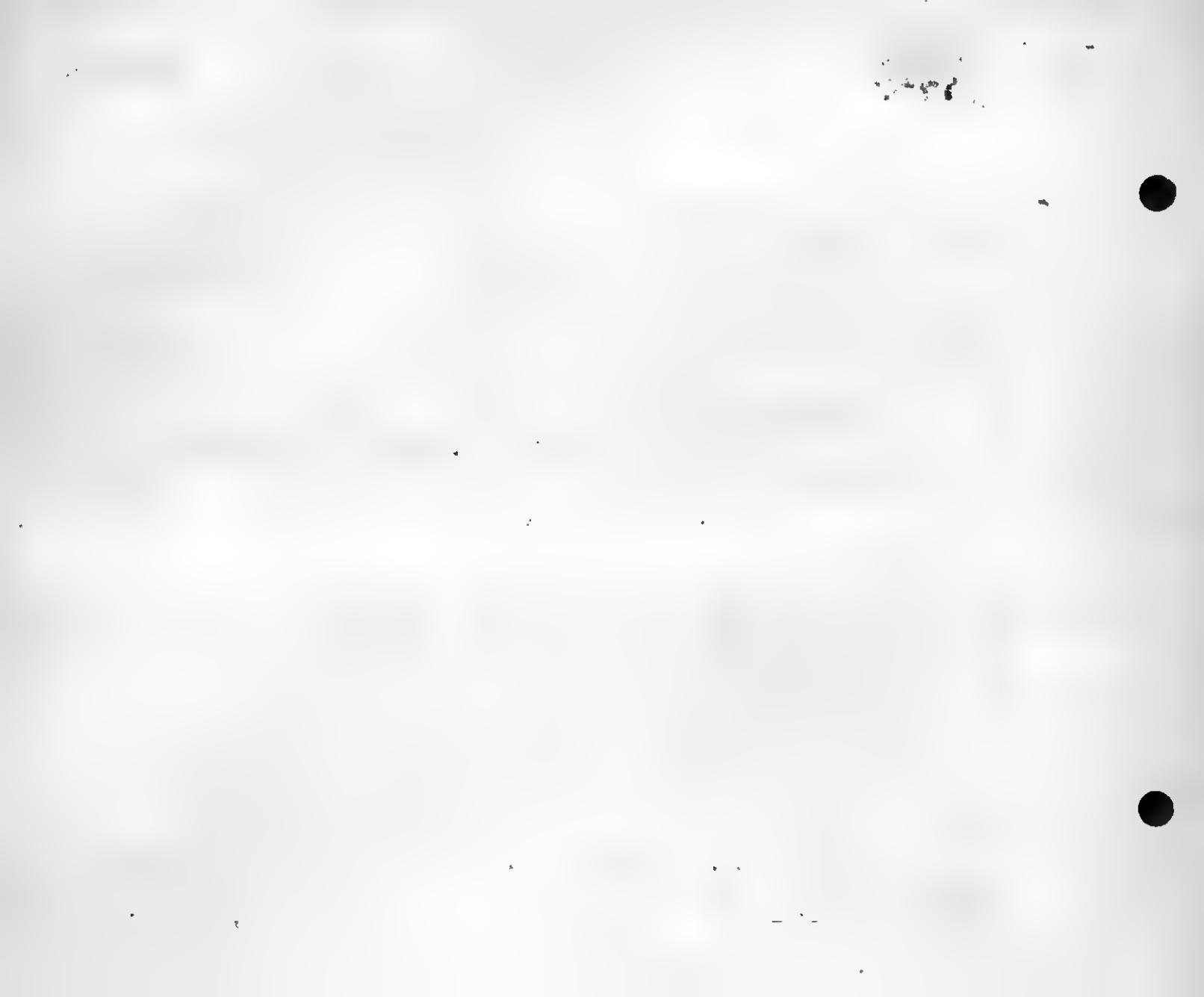
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17689

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Prince George's MARYLAND		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. COUNTY Prince George's	
Cheverly DQA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Allentown	
Prince George General Hospital		d. STREET ADDRESS	
99		6236 Oaklawn Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Konsta	Middle Paulson
4. DATE OF DEATH		Month 12	Day 8 Year 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH	
Retired		9. AGE (in years last birthday) 73 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Finland	
Carpenter		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Paul Paulson		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Senja H. Paulson Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure			
DUE TO Hypertensive arteriosclerotic heart disease		over 14 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE		John Kehoe, M.D.	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. METHOD OF CREMATION, 23b. DATE THEREOF X Cremation		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory	
12-12-1966		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR		ADDRESS	
Simmons Bros. 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR DEC 12 1966 25b. REGISTRAR'S SIGNATURE John Kehoe, Judge	
VR AISM 5 5M 1/65		DATE	



1  
173

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

17695

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 7, 11, 12 Film 353 12/12/66 mn

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17690

1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY <b>Prince George's</b>		a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>1329 Flowers Lane</b>	
3 NAME OF DECEASED (Type or print) <b>Viola M Perry</b>		4 DATE OF DEATH 12 3 19 66	
First	Middle	Month	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> 8. DATE OF BIRTH <b>28 Feb. 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas V. Perry</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  (b) (c) DUE TO <b>Hypertensive arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH minutes over 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <b>Riverdale, Md.</b>			
22. DATE SIGNED <b>12-4-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/7/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>7601 Sheriff Rd. Md.</b>	
24. FUNERAL DIRECTOR <b>Rollins</b>		ADDRESS <b>4339 Hunt Pl N.E.</b>	
		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>																	
17696						17691											
1. PLACE OF DEATH a. COUNTY <b>Prince George County</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Maryland b. COUNTY <b>XX102X MARYWOOD XX56. Pr. George.</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>			c. LENGTH OF STAY IN lb <b>1 mo. 13 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>			d. STREET ADDRESS <b>7102-Marywood St.</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing &amp; Rehabilitative Ctr.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <b>Doris</b>	Middle <b>Ann</b>	Last <b>Phares</b>	4. DATE OF DEATH <b>12</b>	Month <b>12</b>	Day <b>13</b>	Year <b>1966</b>	IF UNDER 1 YEAR Months <b>42 yrs.</b>	IF UNDER 24 HRS Days <b>42 hrs.</b>	Hours <b>0 min.</b>						
S SEX <b>F</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4/8/24</b>	9. AGE (In years last birthday) <b>42 yrs.</b>			10. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) <b>Caswell Co North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>								
13. FATHER'S NAME <b>Charles L. Gammon</b>						14. MOTHER'S MAIDEN NAME <b>Lucy Giles</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No; if unknown) If yes give war or dates of service <b>No</b>			16. SOCIAL SECURITY NO <b>224-28-0786</b>			17. INFORMANT <b>Richard J. Yerak (fellow Executor)</b>			Address <b>8513-Long- St., Hy., Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Metastatic Cancer</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>											
(b) DUE TO DUE TO (c) DUE TO <b>Intestinal Obstruction</b> <b>Metastatic Cancer</b> <b>Originating in Colon</b>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Metastasis to spine hip &amp; leg.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18) <b>Metastasis to spine hip &amp; leg.</b>			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/31/66</b> to <b>12/15/66</b> that (I) (we) last saw the deceased alive on <b>12/12/66</b> , and that death occurred at <b>3:55 AM</b> from causes and on the date stated above.																	
22a. SIGNATURE <b>Kelvin L. Minchin</b>		M.D.			ATTENDING PHYS			<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS		22b. DATE SIGNED <b>12/13/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>KELVIN L. MINCHIN</b>								22d. ADDRESS <b>6400 MARLBORO PIKE SE</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/16/66</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City or Town) <b>Colmar Manor, Md.</b>									
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier Maryland</b>			24b. REG'D BY REGISTRAR <b>DEC 15 1966</b>			25. DESTR'S SIGNATURE <b>Charles Judge</b>									



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item / film 12/22/66 mn

17697

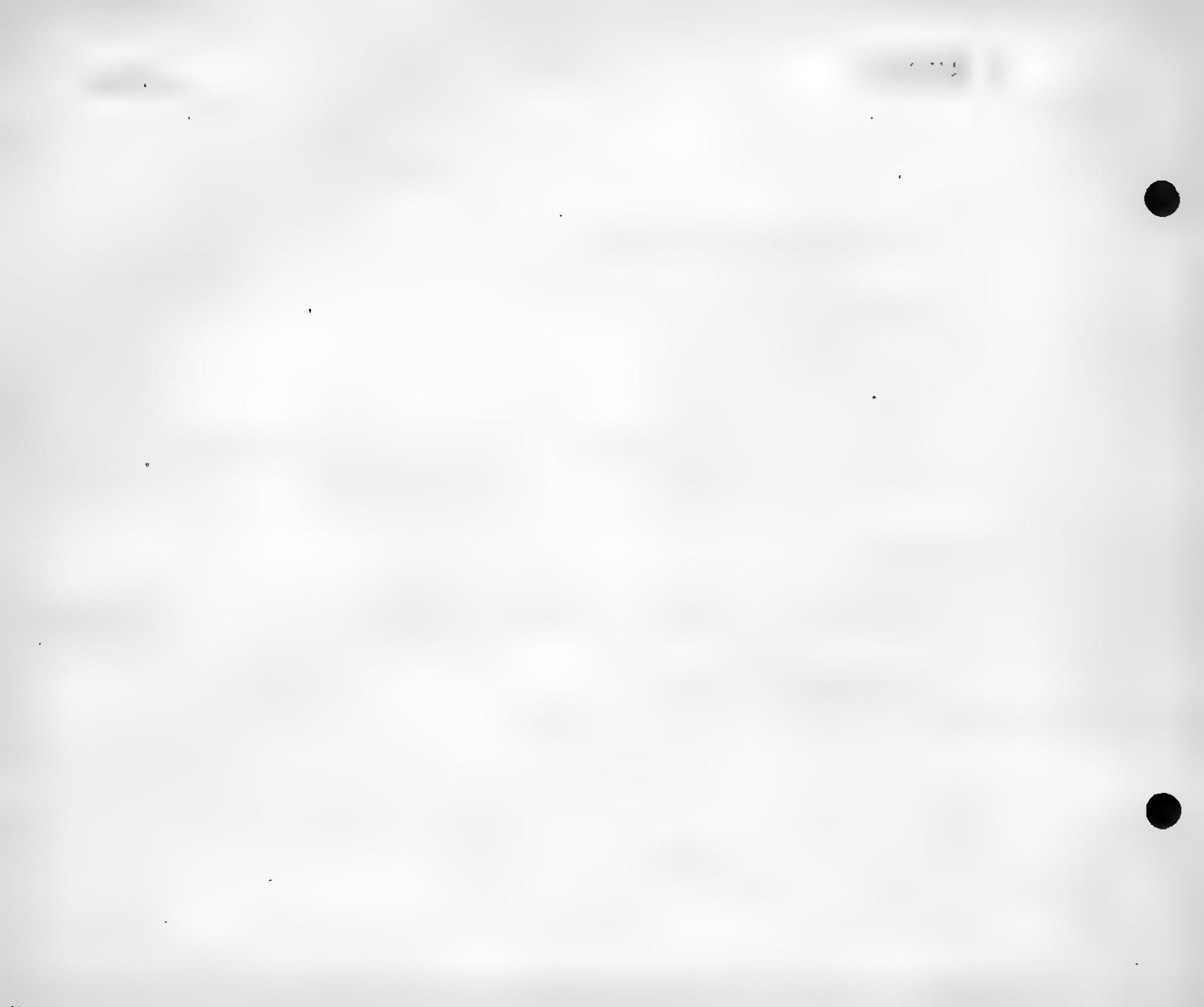
## CERTIFICATE OF DEATH

17692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3216 Chillum Road			
				e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Mary Middle Virginia Last Poore		4. DATE OF DEATH Month December Day 8, Year 66					
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/4/88	9. AGE (In years 78 Last birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min	
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Beavers				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217 52 6057		17. INFORMANT Address Hospital records Cheverly, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i>				INTERVAL BETWEEN ONSET AND DEATH 1 year			
1774 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12, 1966</u> , to <u>Dec. 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8, 1966</u> , and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <i>Charles C. Hagege</i>				22b. DATE SIGNED <u>Dec. 8, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <i>Charles C. Hagege M.D.</i>				22d. ADDRESS <u>3308 Perry St. Mt. Rainier, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 12, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR	
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
						DATE DEC 15 1966	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17698

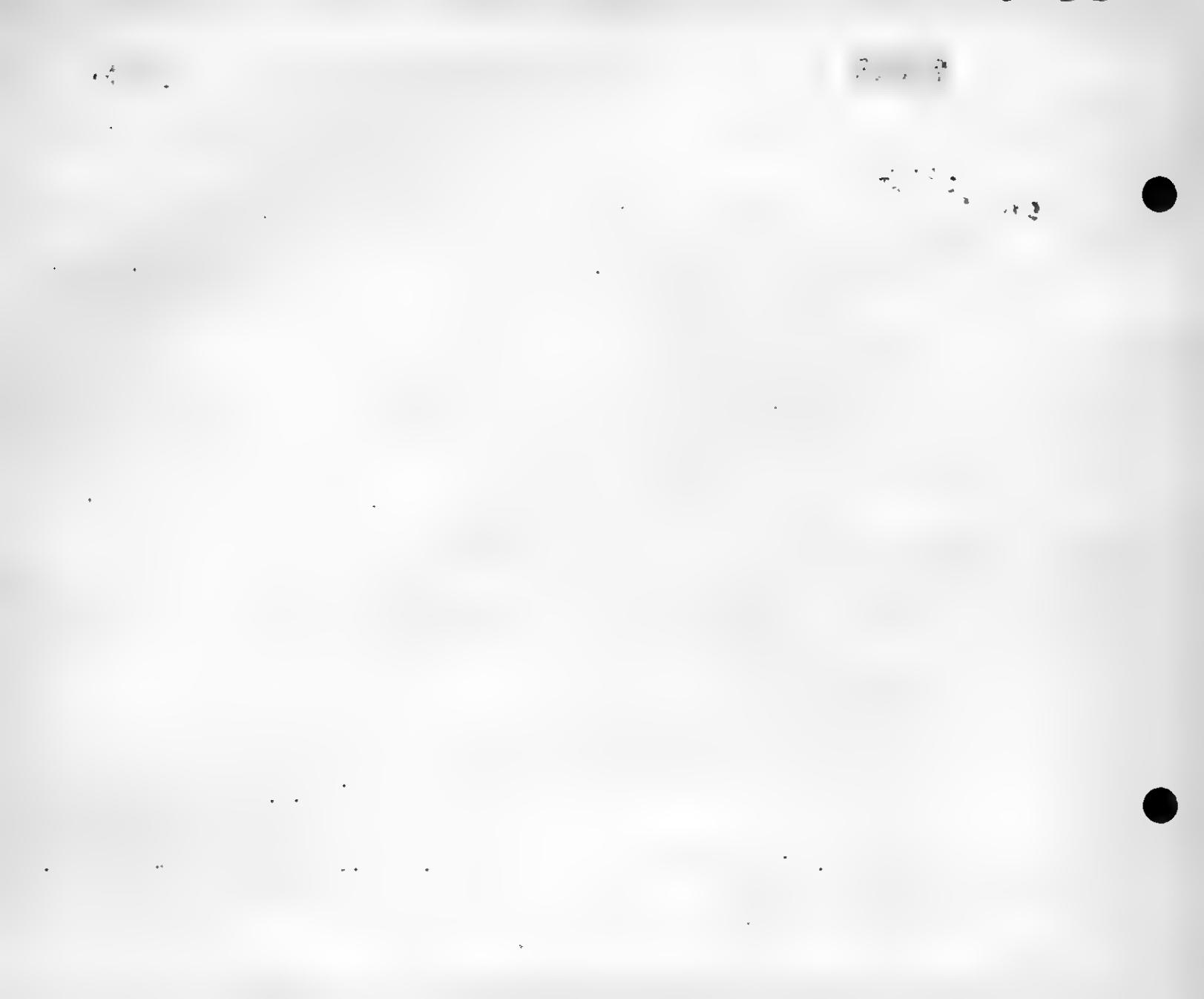
## CERTIFICATE OF DEATH

17699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's		
b CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Cheverly		c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Palmer Park		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General Hospital		d STREET ADDRESS 8343 Allendale Drive e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Wallace Middle E. Last Posey		4 DATE OF DEATH Month December Day 19 Year 1966		
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/10/08	
10a USA. OCCUPATION (Give kind of work done during most of working life, even if retired) Silver Polisher		10b KIND OF BUSINESS OR INDUSTRY Dept Store		
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles F. Posey		14. MOTHER'S MAIDEN NAME Nora		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service NO		16. SOCIAL SECURITY NO. 579 09 2062 17. INFORMANT Blanche V Posey Address Palmer Park, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Acute Coronary Occlusion INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple pulmonary emboli 1 week (c) pneumonia 1 day				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/13, 1966, to 12/19, 1966 that (I) (we) last saw the deceased alive on 12/19, 1966, and that death occurred at 10:50M, from causes and on the date stated above.				A.M.
22o. SIGNATURE <i>Dr. Till Bergemann</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/19/66	
22c. PHYSICIAN'S NAME (Type) Dr. Till Bergemann		22d. ADDRESS Prof. Bldg., Centerway, Greenbelt, Md.		
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D. BY REGISTRAR DEC 23 1966
				25b. REGISTRAR'S SIGNATURE <i>J. J. J.</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17699

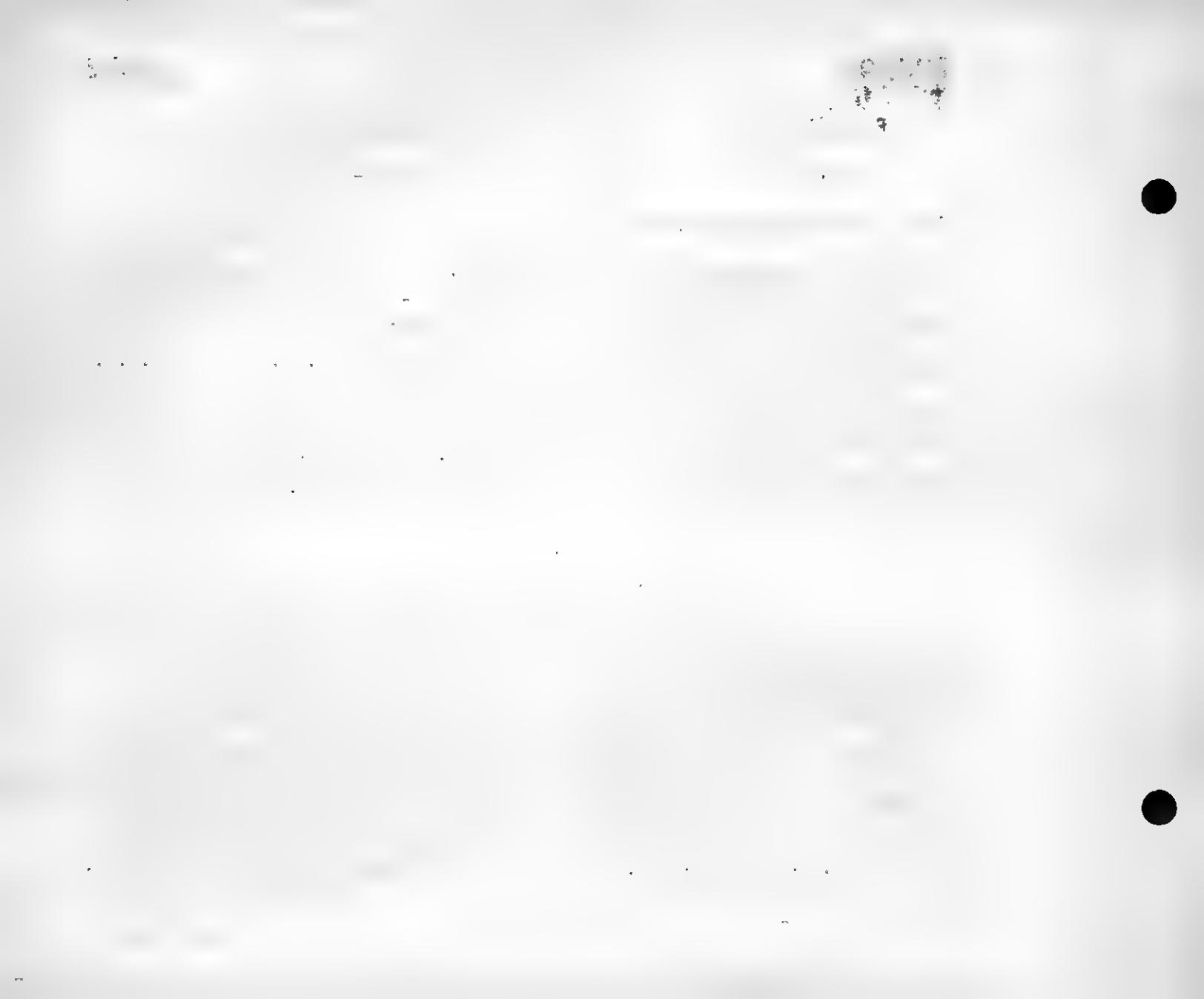
## CERTIFICATE OF DEATH

17694

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>2806 74th Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Gertrude</b>	Middle <b>L</b>	Last <b>Potts</b>
4. DATE OF DEATH <b>Dec., 13 1966</b>	Month	Day	Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>19-11-1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>76 yrs.</b>
		11. BIRTHPLACE (County & State or foreign country) <b>Washington, D. C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Bennett F. McFarland</b>		14. MOTHER'S MAIDEN NAME <b>Addie Chesser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT <b>Kelsa L. Potts 2806 74 th Avenue</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause just. <b>Centri Vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH	
(b) <b>Hypertension</b>			
(c) <b>A.I.S.H.D.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Landover Road, Cheverly, Md.</b>
20f. (City or town) <b>Arlington</b>		(County) (State) <b>Virginia</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/13 1966</b> , to <b>12/13 1966</b> , that (I) (we) last saw the deceased alive on <b>12/13 1966</b> , and that death occurred at <b>3:45 AM</b> , from causes and on the date stated above		22b. DATE SIGNED <b>12/13/66</b>	
22a. SIGNATURE <b>Barry Rosenberg</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>6501 Landover Road, Cheverly, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Barry Rosenberg</b>		23d. LOCATION (City or Town) <b>Arlington</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-16-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		ADDRESS <b>4308 Suitland Rd Suitland Maryland</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
		DATE <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17700

CERTIFICATE OF DEATH

17695

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 2404 Keyberry Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Richard	Middle E.	Last Pranschke	4. DATE OF DEATH Dec. 10, 1966	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH Sept 26, 1928	9. AGE (In years lost birthday) 38 yrs	IF UNDER 1 YEAR Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President		10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (County & State, or foreign country) Indiana	
13. FATHER'S NAME Gustav E. Pranschke			14. MOTHER'S MAIDEN NAME Emma A. Mentzel		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes Korean		16. SOCIAL SECURITY NO. 579 34 2780		17. INFORMANT Charlotte D. Pranschke Same as #2 (wife) Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sub - Brachiocephalic Hernorrhage INTERVAL BETWEEN ONSET AND DEATH					
J. C. X DUE TO 12-1-66 to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ 12-10-66					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 61, to Dec , 19 66 that (I) (we) last saw the deceased alive on Dec 10, 19 66 and that death occurred at 12:35PM, from causes and on the date stated above.					
22a. SIGNATURE <i>Aaron Deitz</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Dec 10, 1966.		
22c. PHYSICIAN'S NAME (Type) Aaron Deitz			22d. ADDRESS Pro Geo Plaza Hyattsville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 14, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			ADDRESS		25a. REC'D BY REGISTRAR
					25b. REGISTRAR'S SIGNATURE DATE DEC 10 1966 Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17701

CERTIFICATE OF DEATH

17696

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	
3. NAME OF DECEASED (Type or print) <b>James</b> First <b>R.</b> Middle		d. STREET ADDRESS <b>Box 193, Davis Road</b>	
3. SEX <b>Male</b> 6. COLOR OR RACE <b>Colored</b>		4. DATE OF DEATH Month <b>December</b> , Day <b>16</b> , Year <b>1966</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. DATE OF BIRTH <b>10/4/92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Worker</b>		9. AGE (In years lost birthday) <b>74 yrs</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Charles County</b>	
13. FATHER'S NAME <b>James Proctor</b>		12. CITIZEN OF WHAT COUNTRY? <b>Mary V. Proctor</b>	
14. MOTHER'S MAIDEN NAME		15. INFORMANT <b>Charlotte Proctor</b> Address <b>Baptist, Md.</b>	
16. SOCIAL SECURITY NO. <b>2-13-16-28424</b>		17. INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Anemia, arteriole (coronary) fibr + Dism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhage</b> DUE TO <b>Myocardial infarct.</b> (c)		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>pm.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <b>Landover</b> (County) <b>Md.</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1966</b> to <b>Dec. 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 15, 1966</b> , and that death occurred at <b>3:45 M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>12/16/66</b>	
22a. SIGNATURE <b>Channes Sahakyan</b>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>M.D.</b> <b>A</b>	
22c. PHYSICIAN'S NAME (Type) <b>Channes Sahakyan, M.D.</b>		22d. ADDRESS <b>5813 Landover Rd., Cheverly, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-20-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Joseph Catholic Church, Pomfret, Chas. Co. Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS <b>Midwest Adams Agencies, Md.</b>		25a. REC'D BY REGISTRAR <b>JEC 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

17

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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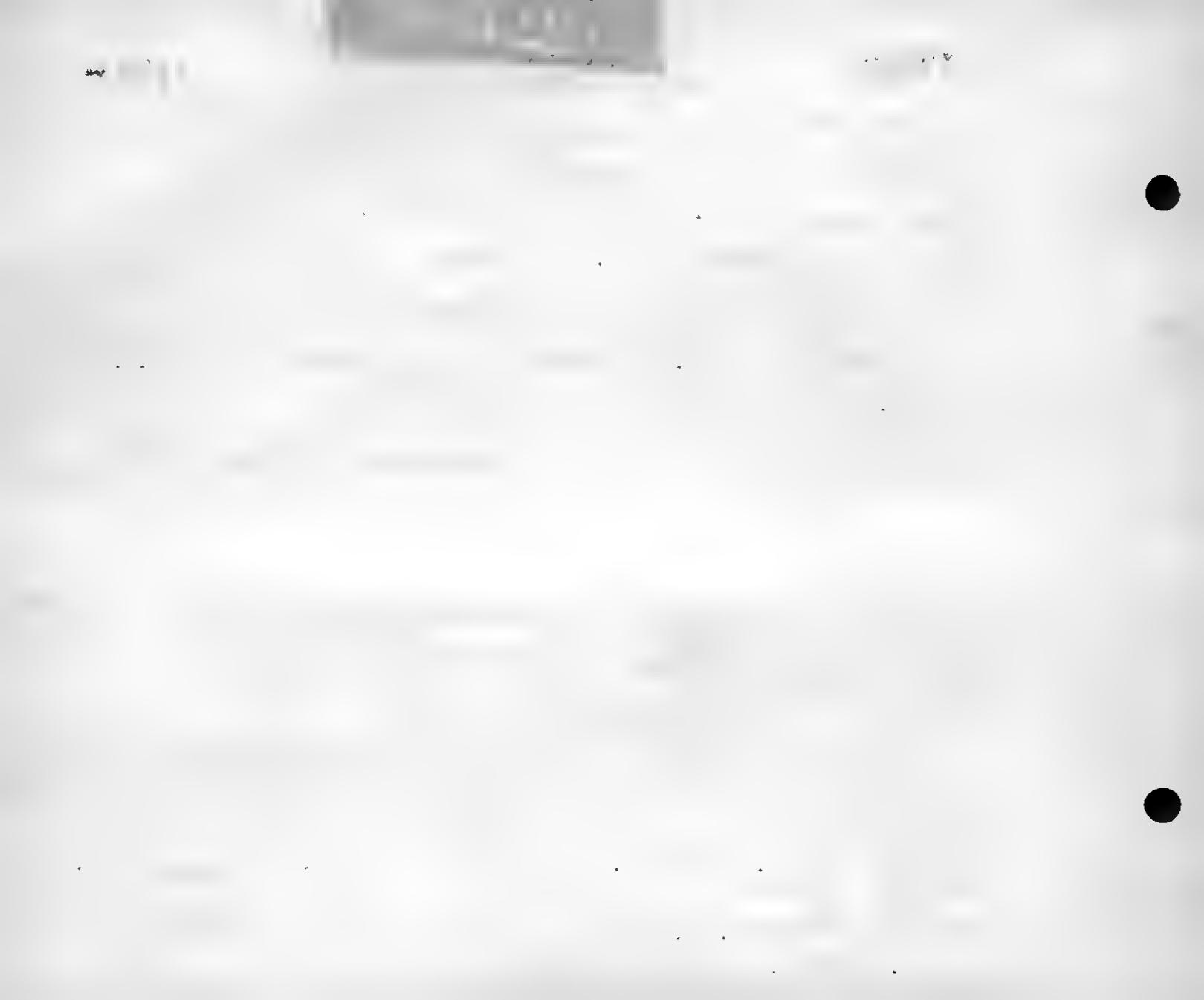
## CERTIFICATE OF DEATH

17697

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.~~

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNT Prince George's		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb 21 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d STREET ADDRESS 5218 58th Ave.		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Albert	Middle H.	Lost Radisch	4 DATE OF DEATH December 28 1966	Month Day Year Month Days Hours Min
S SEX Male	6 COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH 9/10/1880 2/13	9 AGE (In years last birthday) 52 53 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11 BIRTHPLACE (County & State or foreign country) Brentwood, Maryland	
13. FATHER'S NAME Herman A. Radisch			14. MOTHER'S MAIDEN NAME Evelyn Bless		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO 579-10-1635		17. INFORMANT Virginia Radisch Address 5218 58th Avenue Riverdale, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>Generalized 1965</i>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-3, 1966, to 12-28, 1966, that (I) (we) last saw the deceased alive on 12-28, 1966, and that death occurred at 9:45 AM, from causes and on the date stated above.					
22a. SIGNATURE <i>George J. Hageage</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 12-28-66		
22c. PHYSICIAN'S NAME (Type) George J. Hageage, M.D.		22d. ADDRESS 3717 38th Ave., Cottage City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 28, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.	ADDRESS 8434 Georgia Avenue Silver Spring, Md.	25a. REC'D BY REGISTRAR DATE JAN 3 1967	25b. REGISTRAR'S SIGNATURE <i>George J. Hageage</i>		



FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17703

17698

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Prince George's MARYLAND		b. STATE Kentucky b. COUNTY Union	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Glenn Dale five days		Sturgis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10041 Locust Street		Route 1	
3. NAME OF DECEASED (Type or print)	First Tenrie	Middle Bernice	Last Reed
4. DATE OF DEATH	Month 12	Day 16	Year 1966
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1, 1906
9. AGE (in years last birthday) 60 yrs.	10. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Clark	14. MOTHER'S MAIDEN NAME Rhoda		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
"Joy Lee Reed Sturgis Kentucky			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure			
DUE TO (b) Arteriosclerotic Heart Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c)			
five years			
INTERVAL BETWEEN ONSET AND DEATH (minutes)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED
		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	12-17-66
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland Address (Street, city, town, or county)			
23a. BURIAL, CREMATION / REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 21, 1966	23c. NAME OF CEMETERY OR Crematory Rythian Ridge Cemetery	23d. LOCATION (City, town or county) Sturgis Kentucky (State)
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DATE DEC 22 1966			



DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17704

## CERTIFICATE OF DEATH

17704

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 8311 Allendale Drive		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Baby	Middle Girl	Last Remick	4. DATE OF DEATH December 17, 1966	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/15/66	9. AGE (In years last birthday) yrs 1 month 2 days 3 hours 4 min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland U.S. A.	
13. FATHER'S NAME Richard Joseph Remick			14. MOTHER'S MAIDEN NAME Judith Lee Brutsche		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Father Address As above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO _____  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					
INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1966, to Dec. 17, 1966, that (I) (we) last saw the deceased alive on Dec. 17, 1966, and that death occurred at 12:50 P.M. from causes and on the date stated above.					
22a. SIGNATURE Andrew G. Aronoff, M.D.		22b. DATE SIGNED Dec. 18, 1966			
22c. PHYSICIAN'S NAME (Type) Andrew G. Aronoff, M.D.		22d. ADDRESS 6803 Good Luck Road, Lanham, Md.			
23a. BURIAL, CREMATION, Cremation		23b. DATE THEREOF 12/24/66	23c. NAME OF CEMETERY OR CREMATORIAL Prince Georges Gen. Hosp.	23d. LOCATION (City or Town) Cheverly	(County) (State) Maryland
24. FUNERAL DIRECTOR Harold W. Penn, Jr., Amin.		ADDRESS Cheverly, Maryland	24a. REGD BY REGISTRAR DEC 20 1966	24b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20 M 1/66			DATE		

MARYLAND STATE

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17705

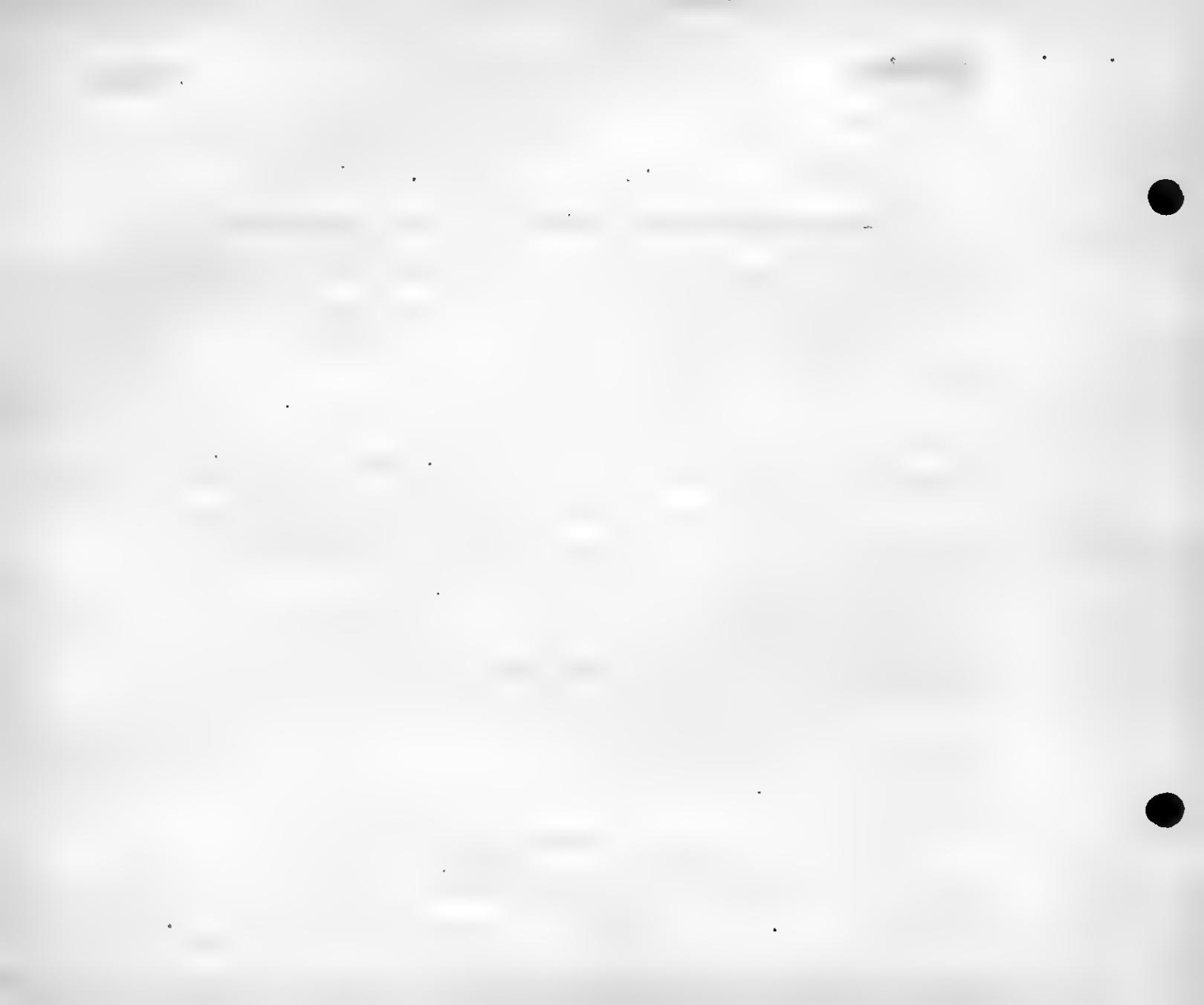
CERTIFICATE OF DEATH

17701

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) d. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) <b>Mt. Rainier</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>3414 Newton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ruth E Richards</b>		First	Middle	Last	4. DATE OF DEATH Dec 1966	Month	Day	Year
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June 1898</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Nurse</b>		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Charles Kendall</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Carter</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles T. Richards Same as Item #2</b>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____			Shock					INTERVAL BETWEEN ONSET AND DEATH
577X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			Gangrene of clavum Adhesions					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Aspiration pneumonia, acidosis</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/21</b> , 1966, to <b>12/3</b> , 1966, that (I) (we) last saw the deceased alive on <b>12/3</b> 1966, and that death occurred at <b>1:45 AM</b> from causes and on the date stated above.								22b. DATE SIGNED <b>12/3/66</b>
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. BAILY</b>			22d. ADDRESS <b>1835 EYE N.W. WASH 6 D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 6-1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Md.</b>		
24. FUNERAL DIRECTOR <b>Simmons Bros 1661 Good Hope Rd. SE</b>		ADDRESS		25a. REG'D BY REGISTRAR <b>JED 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James George</b>		
				DATE				



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

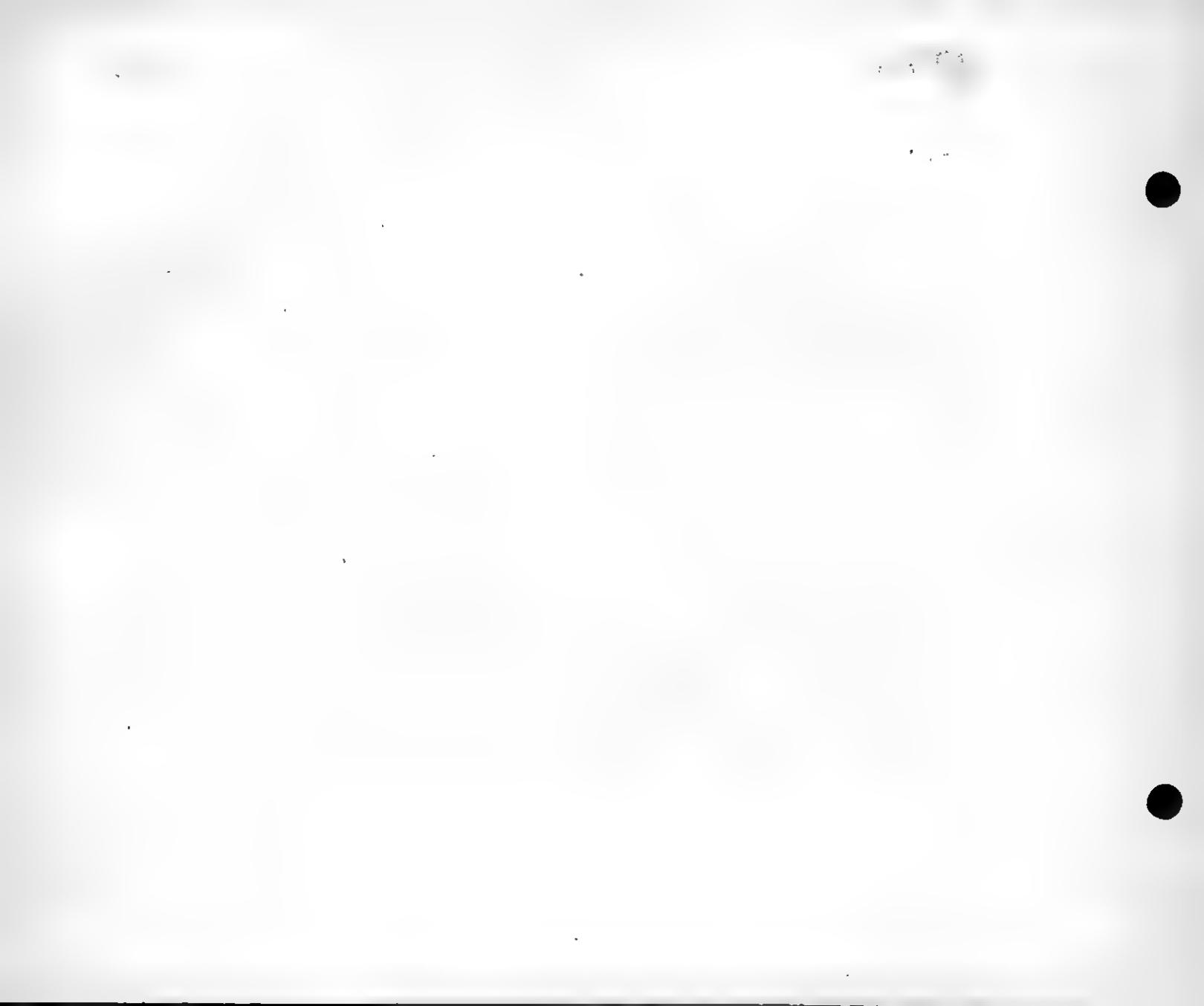
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17702

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate mts, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb DOA		c CITY OR TOWN (If outside corporate mts, write RURAL and give nearest town) Washington	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d STREET ADDRESS 7 Needles Green, S.C.		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			e STREET ADDRESS 4713		
3. NAME OF DECEASED (Type or print) Charles E. Compton		First	Middle	Lost	4 DATE OF DEATH Month Day Year 12-10-1966
5. SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 26 June, 1942	9 AGE (in years last birthday) 26 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. JEWEL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICEMAN		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11 BIRTHPLACE (State or foreign country) CALIFORNIA	
13. FATHER'S NAME Charles E. Compton		14. MOTHER'S MARRIED NAME Theresa		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes ACTIVE		16. SOC. SECURITY NO 562-54-4988		17. INFORMANT Mary V. RICHMOND	
				Address SECT 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade and left hemithorax DUE TO 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot wound of chest (32 cal.) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest			
20c. TIME OF INJURY Month, Day, Year hour am xx 12 10 19 66		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville, Md. Picnic area off Queens Chapel Rd nr Hamilton St		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 12-11-66	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		Address (Street, city, town, or county)			
23a. BURIAL/CREMATION REMOVAL (Specify) 12/14/66		23b. DATE THEREOF 12/14/66	23c. NAME OF CEMETERY OR CREMATORIAL BARRENCAAS NATL. PENSACOLA, FLA.		23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR W.W. CHAMBERS CO.		5-1 ADDRESS 11TH ST. S.E.	25a. REC'D BY REGISTRAR DEC 15 1956		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
6M 1/66					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17707

## CERTIFICATE OF DEATH

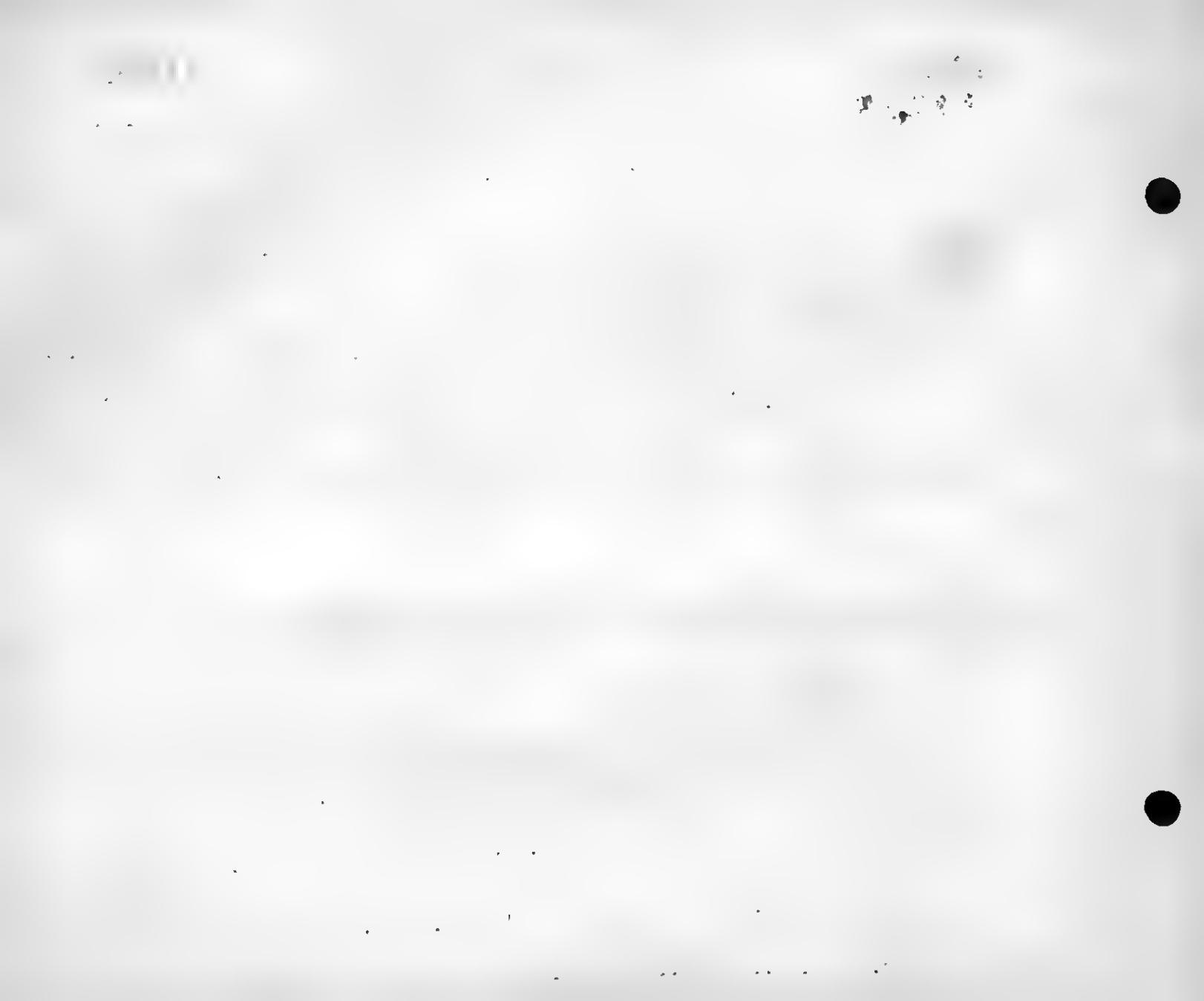
17704

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>13 hrs.15 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>13108 Bellevue Street</b>			
3 NAME OF DECEASED (Type or print) <b>First Baby Boy</b>				4 DATE OF DEATH <b>Month December Day 9, Year 66</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>December 8, 1966</b>	9. AGE (in years lost birthday) <b>yrs</b>	10. UNDER 1 YEAR Months <b>13</b>	11. UNDER 24 HRS. Hours <b>15</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b KIND OF BUSINESS OR INDUSTRY			11 BIRTHPLACE (County & State, or foreign country) <b>Prince Geo., Maryland</b>	
13. FATHER'S NAME <b>Armand Schmidt</b>				14. MOTHER'S MAIDEN NAME <b>Eloise Carolyn Virginia Matthews</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b> Address <b>As above</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subdural Hematoma</b> INTERVAL BETWEEN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 8, 1966</b> , to <b>December 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 9, 1966</b> and that death occurred at <b>12:00M</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED <b>12/12/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>M. D.</b> <b>Berardo Alvarado</b>		22d. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12/17/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Prince George's Gen. Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly PG Maryland</b>	
24. FUNERAL DIRECTOR <b>Harvey N. Penn, Jr., Admin., Cheverly, Maryland</b>		ADDRESS		25a. RECD BY REGISTRAR <b>Charles J. ...</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17705

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale DOA	c LENGTH OF STAY IN lb	c. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Mt. Rainier	d STREET ADDRESS 2704 Upshur Street, Apt. 5			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) First Alyce Middle Rita Last Schneider		4 DATE OF DEATH Month Day Year 12 28 1966				
S. SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY U.S. Government				
11. BIRTHPLACE (State or foreign country) Pennsylvania		9. AGE (In years lost birthday) yrs 61				
13. FATHER'S NAME Patrick J. Lyons		14. MOTHER'S MAIDEN NAME Mary A. Sullivan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO Unknown				
17. INFORMANT Barbara A. Rayner		8012 Park Lane Bethesda, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes - known over 15 yrs.						
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour am p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 12-28-66		
EXAMINER'S NAME (Type) John Kehoe, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/66	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Washington D.C.
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

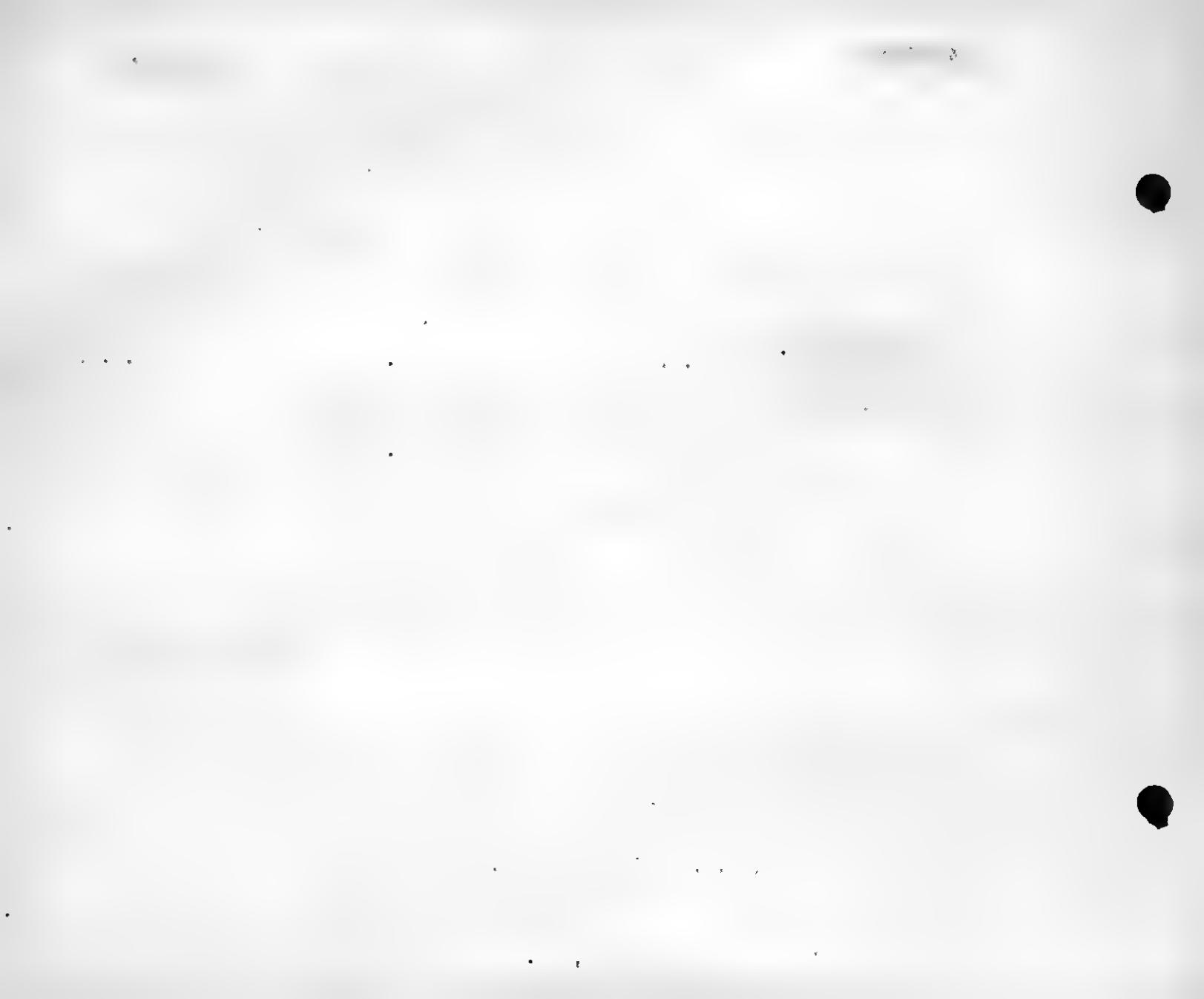
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17706

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George's</b>	
c LENGTH OF STAY IN lb <b>DOA</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5608 Gallitan Place</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward</b>		First <b>M</b>	Middle <b>Sheehan</b>
4. DATE OF DEATH <b>12 28 1966</b>	Month <b>12</b>	Day <b>28</b>	Year <b>1966</b>
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Never Married</b>	8. DATE OF BIRTH <b>17 Dec. 1899</b>
9. AGE (In years lost birthday) <b>67 yrs</b>		10. KIND OF BUSINESS OR INDUSTRY <b>U.S. Goverment</b>	11. BIRTHPLACE (State or foreign country) <b>Mass.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edward M. Sheehan</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ann Burns</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577 34 6192</b>	
17. INFORMANT <b>Katherine O. Sheehan Same as #2 (wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH minutes <b>over 5 yrs.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <b></b>
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b></b>	
ACTUAL SIGNATURE <i>John Kehoe</i>		22. DATE SIGNED <b>12-28-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b DATE THEREOF <b>12/30/66</b>		23c NAME OF CEMETERY OR CREMATORIALy <b>Arlington National</b>	
24 FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		23d LOCAT ON (City or Town) (County) (State) <b>Hyattsville, Md. Arlington Arlington Va.</b>	
ADDRESS		25a REC'D BY REGISTRAR DATE JAN 3 1967	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 13, 14 To information from birth cert.

17710

## CERTIFICATE OF DEATH

17707

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. The ~~please remove carbon paper~~ <sup>1 and 2</sup> director, page 3 should be detached for use as the burial-transit permit. The ~~please remove carbon paper~~ <sup>1 and 2</sup> director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>			b. COUNTY <b>Anne Arundel</b>		
c. LENGTH OF STAY IN 1b <b>15 hours</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita., give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>1610 Annapolis Road</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Baby	Middle Girl	last Shifflett	4. DATE OF DEATH Month December Day 7 Year 1966
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>12/6/66</b>	9. AGE (In years lost birthday) yrs. <b>Pr. Geo's Co., Md.</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (County & State, or foreign country) <b>Mary Ann Shifflett</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Shifflett</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Prematurity (1360 gms.)</b>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, laundry, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>66</b> , to <b>12/7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/7</b> , 19 <b>66</b> , and that death occurred at <b>10a.</b> M, from causes and on the date stated above					
22a. SIGNATURE <b>Dr. Van Gelderen</b>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Van Gelderen</b>		22d. ADDRESS <b>3001 Cheverly Ave., Cheverly, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL/Permit <b>Cremation</b>		23b. DATE THEREOF <b>12/17/66</b>	23c. NAME OF CEMETERY OR CREMATORIALy <b>Prince George's Gen. Hosp.</b>	23d. LOCATION (City or Town) <b>Cheverly</b>	(County) (State) <b>PG Maryland</b>
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin., Cheverly, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>12/21/1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. W. Penn</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 11, 12, 13, 14, 23a, 23d Film G-3 11/14/66 mhFOR STATE  
HEALTH DEPT.

17711

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17708

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chamber's Funeral Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>		f. STREET ADDRESS <b>6717 Rock Road</b>		g. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Bernard</b>		First <b>Augusta</b>		Middle <b>Simms</b>		4. DATE OF DEATH <b>12 1 1966</b>	Month	Doy	Year	
S SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <b>Never married</b>	NEVER MARRIED <b>Divorced</b>	X	8. DATE OF BIRTH <b>16 JULY 1938</b>	9. AGE (in years last birthday) <b>28 yrs</b>	10. UNDER 1 YEAR Months <b>0</b>	11. UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10. OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Augustus G. Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Simms</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>492X</b> lost						INTERVAL BETWEEN ONSET AND DEATH Minutes				
(b) <b>Bilateral pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost						Days				
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <b>12-3-66</b>		
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
				Address (Street, city, town, or county) <b>Oxon Hill, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/8/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul Methodist Church Cemetery		23d. LOCATION (City or Town) <b>Oxon Hill</b>		(County) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Robert G. Liaison Funeral Home, Inc.</b>		ADDRESS <b>2500 Nichols Avenue, S.E., Washington 20, D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delayed, please execute the certificate, writing the word 'Pending' in **Item 18**. Give Pages 1, 2, and 3 to the funeral director. Page 1 **must** be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17712

## CERTIFICATE OF DEATH

17709

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

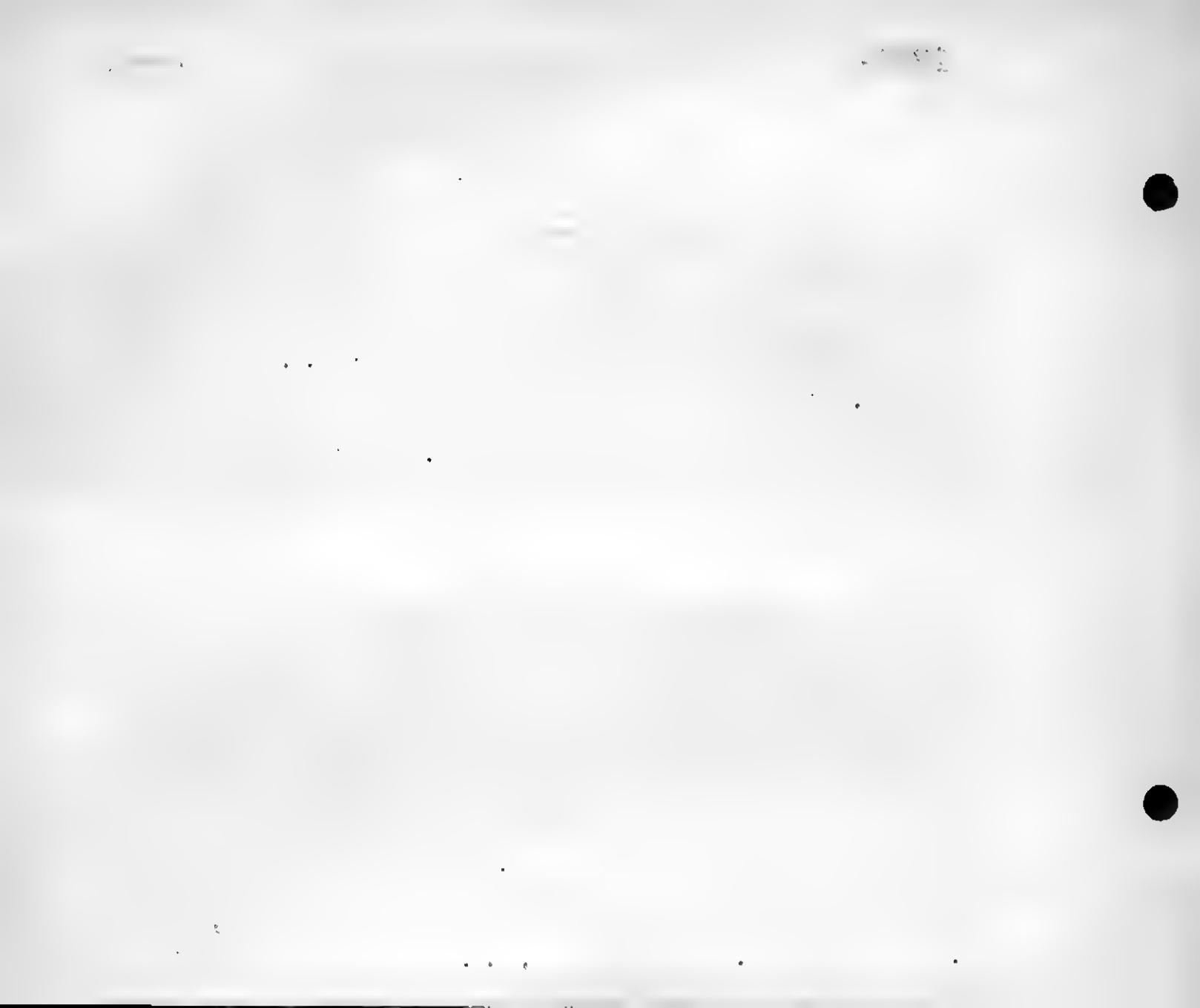
1 PLACE OF DEATH a COUNTY PRINCE GEORGE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE VIRGINIA b. COUNTY FAIRFAX		
b CITY OR TOWN (If outside corporate limits, write PLURAL and give nearest town) ANDREWS AIR FORCE BASE		c LENGTH OF STAY IN TB DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS, ANDREWS AFB			d STREET ADDRESS 6326 BERYL ROAD		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED First BESSIE Middle V SMITH		4. DATE OF DEATH DECEMBER 27 1966		Month Day Year	
(Type or print) OR BESSICA		5. SEX FEMALE CAU		6. COLOR OR RACE	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 18 DEC 1917		9. AGE (in years last birthday) 49 yrs	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10b. KIND OF BUSINESS OR INDUSTRY n/a		11. BIRTHPLACE (County & State, or foreign country) MISSOURI	
10a. US. OCCUPATION (Give kind of work done during most of work life, even if retired) HOUSEWIFE		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME CHARLES EUGENE CHAMBERLIN			14. MOTHER'S MAIDEN NAME Not Known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 577-30-2908		17. INFORMANT HUSBAND SAME AS # 2 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE			19. INTERVAL BETWEEN ONSET AND DEATH minutes		
20a. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			Years		
(b) LIVER DISEASE			Years		
(c) POSSIBLE ALCOHOLISM			Years		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20c. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20g. (City or Town) (County) (State)	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>23 JUNE</u> , 19 <u>65</u> , to <u>27 DEC</u> , 19 <u>66</u> , that <u>10</u> (we) lost saw the deceased alive on <u>23 NOVEMBER 1966</u> , and that death occurred at <u>5:15 AM</u> from causes and on the date stated above.					
22a. SIGNATURE <u>David S. Teperson</u>			AM 22b. DATE SIGNED 27 DEC 66		
22c. PHYSICIAN'S NAME (Type) DAVID S. TEPPERSON			22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASH. D.C. 20331		
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF 12-30-66		23c. NAME OF CEMETERY OR CREMATORIAL <u>ARLINGTON NATIONAL</u>	
23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VIRGINIA</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Jr.</u>		ADDRESS <u>3072 W. ST. N.W. WASH. D.C.</u>	
25a. REC'D BY REGISTRAR <u>DEC 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>W.W. Chambers Jr.</u>			



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 9 Film 383 1/12/66 nn <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
Item 8 Film G384 12/22/66 nn											
1 PLACE OF DEATH a. COUNTY Prince George's			MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE Maryland			b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden Woods			d. STREET ADDRESS 7920 Echols Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) James			First William			4 DATE OF DEATH Month 12			Month Day 19 Year 66		
5 SEX Male		6 COLOR OR RACE Negro		7 MARRIED WIDOWED		8 DATE OF BIRTH 3 27 Dec. 1924		9 AGE (In years 41 lost birthday) 102 yrs		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Government Employee			10b. KIND OF BUSINESS OR INDUSTRY			11 BIRTHPLACE (State or foreign country) Washington, D.C.			12 CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James E. Smith			14. MOTHER'S MAIDEN NAME Mary Morton								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO.			17. INFORMANT Marzel G. Smith 7920 Echols Avenue			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral pneumonitis</u>									INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 492X			DUE TO (b)			DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Lechoe</i>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 12-2-66		
EXAMINER'S NAME (Type) John Lechoe, M.D.			Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) 31st			23b. DATE THEREOF 12/16/1966			23c. NAME OF CEMETERY OR CREMATORIAL Arlington			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR W. Ernest Jarvis Co.			ADDRESS 1132 You Street, N.W.			25a. REC'D BY REGISTRAR DATE DEC 7 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15ME (5) 6M 1/66											



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17714

## CERTIFICATE OF DEATH

17711

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	c LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 5003 37th. Pl.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Alice	Middle Lee	Last Souder
4 DATE OF DEATH 12-29-66	Month 12	Day 29	Year 1966
5 SEX Fe	6 COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8 DATE OF BIRTH 2-2-11	9 AGE (in years - lost birthday) 55 yrs	10. KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (County & State, or foreign country) W. Virginia
12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John David Sears	14. MOTHER'S MAIDEN NAME Lula Lewis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Deyerle B. Souder Address (Same as # 2) Medical Record and Husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  7d0.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	ACUTE PULMONARY EDEMA		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
DUE TO (b) ACUTE MYOCARDIAL INFARCTION			6 DAYS
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 12-23-66, 1966, to 12-29-66, that (I) (we) last saw the deceased alive on 12-29-66, and that death occurred at 3:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 12-29-66	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D.		22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/1/66	23c. NAME OF CEMETERY OR CREMATORIAL Beaver Run Cemetery	23d. LOCATION (City or Town) Keyser (County) (State) W. Va.
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR JAN 3 1967
			25b. REGISTRAR'S SIGNATURE J. W. JONES



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17715

## CERTIFICATE OF DEATH

17712

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~use carbon paper~~ Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and one event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>D O A</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Norval H Spicknall</b>		d. STREET ADDRESS <b>12015 Old Gunpowder Road</b>	
4. DATE OF DEATH <b>Dec 21, 1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <b>WIDOWED</b>	8. NEVER MARRIED <b>DIVORCED</b>
9. B. DATE OF BIRTH <b>Aug 9, 1906</b>		9. AGE (in years last birthday) <b>60 yrs</b>	
10. JS/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bio Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept of Agriculture</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pro Geo Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Norval H Spicknall sr</b>		14. MOTHER'S MAIDEN NAME <b>Hester Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO <b>217 44 0512</b>	
17. INFORMANT <b>Stella P Spicknall</b>		Address <b>Beltsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Deitz Coronary Arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) <b>—</b>		(County) <b>—</b>	
(State) <b>—</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>4 - 1, 1950</b> , to <b>12-21, 1966</b> , that (I) (we) last saw the deceased alive on <b>12-21, 1966</b> , and that death occurred at <b>4:21 P.M.</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>12-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A Deitz</b>		22d. ADDRESS <b>Pro Geo Plaza Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 23, 1966</b>	
23c. NAME OF CEMETERY OR CEM. CHAMBERS <b>St Johns Episcopal</b>		23d. LOCATION (City or Town) (County) (State) <b>Beltsville Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>—</b>		25b. REGISTRAR'S SIGNATURE <b>—</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17716

## CERTIFICATE OF DEATH

17713

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial. Interment, or removal, and in any event, with A/72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Geo.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN lb 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d. STREET ADDRESS 4200 - 31st St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4200 - 31st St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) First Mary		Middle M.		Last Spilman		DATE OF DEATH Dec. 29	Month Year 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/4/1910	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tele. Operator		10b. KIND OF BUSINESS OR INDUSTRY Gramercy Inn		11. BIRTHPLACE (County & State, or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Porterfield		14. MOTHER'S MAIDEN NAME Mary E. Bell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Robert M. Spilman (above address Husband)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for Part I or Part II) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause  16 DUE TO 10 Hypertension Cerebral Hemorrhage Cardiovascular - Disease						INTERVAL BETWEEN ONSET AND DEATH Obliterated 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Cardiovascular - Disease							
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1959		20f. (City or Town) (County) (State) Temple Hills, Md.	
21. I certify that (I) (this hospital) attended the deceased from 12/23/66, to 12/24/66, shot (I) (we) last saw the deceased alive on 12/23/66, and that death occurred at 12/24/66, M, from causes and on the date stated above.							
22a. SIGNATURE Gwendolyn Chouette		ATTENDING MD. PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/30/66	
22c. PHYSICIAN'S NAME (Type) NAME		22d. ADDRESS 4400-Stamp Rd., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/31/66		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge DATE JAN 9 1967	
VR A15 (4) 20 M 1/66							



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17717

CERTIFICATE OF DEATH

17714

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Prince George General Hospital		d. STREET ADDRESS 5400--You St., SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ESTELLE	Middle L.	Last STONE	4. DATE OF DEATH Dec. 14th	Month 1966	Day	Year
S. SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 29th, 1912	9 AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY G. S. A.		11 BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Suthard		14. MOTHER'S MAIDEN NAME Lula Wright					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret L. Foley-1905-54th Ave., SE		Bradbury Heights, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 406.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary occlusion Hyperthyroidism and calcification				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-12, 1963 to 12-12, 1966 that (I) (we) last saw the deceased alive on 12-12, 1966 and that death occurred at 5450 M, from causes and on the date stated above.							
22a. SIGNATURE Dr. Arthur T. Jones		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED Dec. 15th 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Arthur T. Jones		22d. ADDRESS 4601-Nichols Ave., SW Wash. DC					
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)		23b. DATE THEREOF Dec. 17-1966		23c. NAME OF CEMETERY OR CREMATORIAL Washington Natl.		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros. 1661-Good Hope Rd SE Wash DC		ADDRESS		25a. REC'D BY REGISTRAR DATE: 12-17-1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17718

## CERTIFICATE OF DEATH

17715

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>			b. COUNTY <b>P.G.</b>		
c. LENGTH OF STAY IN lb <b>11 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. RAINIER</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General</b>			d. STREET ADDRESS <b>4114 31st. Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Marybeth C. Stremeter</b>			4. DATE OF DEATH <b>12 - 30 - 66</b>	Month <b>19</b>	Day <b>66</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <b>Never married</b>	8. DATE OF BIRTH <b>5-11-21</b>	9. AGE (In years last birthday) <b>45 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		
13. FATHER'S NAME <b>Clifford M. Stremeter</b>			14. MOTHER'S MAIDEN NAME <b>Nettie Callan</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>yes</b> <i>Helen M. Beers</i> Address <b>9005 Kirkdale Rd.</b> <b>Bethesda, Md.</b>		
17. INFORMANT <b>John B. Thomas</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO <i>upper gastro-intestinal bleeding</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Advanced cirrhosis of the liver</i> (c)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>Dec. 19, 1966</b> , to <b>Dec. 30, 1966</b> that <b>(H)</b> (we) last saw the deceased alive on <b>Dec. 30, 1966</b> , and that death occurred at <b>8:30 AM</b> , from causes and on the date stated above.			22b. DATE SIGNED <b>12-31-66</b>		
22a. SIGNATURE <b>Ky Choi</b>			M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Ky Choi</b>			22d. ADDRESS <b>Cheverly, Prince Geo. Gen. Hospital, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 3, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warren E. Humphrey, Inc.</b>		ADDRESS <b>843 Georgia Ave. Silver Spring, Md.</b>	25a. REC'D BY REGISTRAR <b>JAN 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Hayes</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEM.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17716

f. PLACE OF DEATH o. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5603 Chillum Heights Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Wesley</b>	Middle <b>Clark</b>	Last <b>Swim</b>
4. DATE OF DEATH	Month <b>12</b>	Month <b>27</b>	Day <b>19</b> Year <b>66</b>
S SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		9. DATE OF BIRTH <b>7-27-1939</b>	
10a. US JAT OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TOLEDO SCALE CO</b>		9. AGE (in years last birthday) <b>27 yrs</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>	
13. FATHER'S NAME <b>HAROLD SWIM</b>		14. MOTHER'S MAIDEN NAME <b>EDITH THOMAS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of serv (ce) <b>YES Nov 23 Dec 1958</b>		16. SOCIA. SECURITY NO <b>578 52 0281</b>	
17. INFORMANT <b>ANNA F. SWIM</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)	
19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRI.BE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item B.) <b>Drowned when boat capsized.</b>	
20c. TIME OF INJURY Month, Day, Year Hour or m <b>3:30pm p.m 12-26-1966</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>Potomac River Cove, 1 mile so. of Wilson Br.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>12-28-66</b>	
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-30-1966</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>FORT LINCOLN</b>		23d. LOCATION (City or Town) <b>BLADENSBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Maryland</b>		25a. REC'D BY REG STRAR DATE JAN 3 1967	
ADDRESS <b>W.W. Chambers Co. Riverdale, Maryland</b>		25b. REG STRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17720

## CERTIFICATE OF DEATH

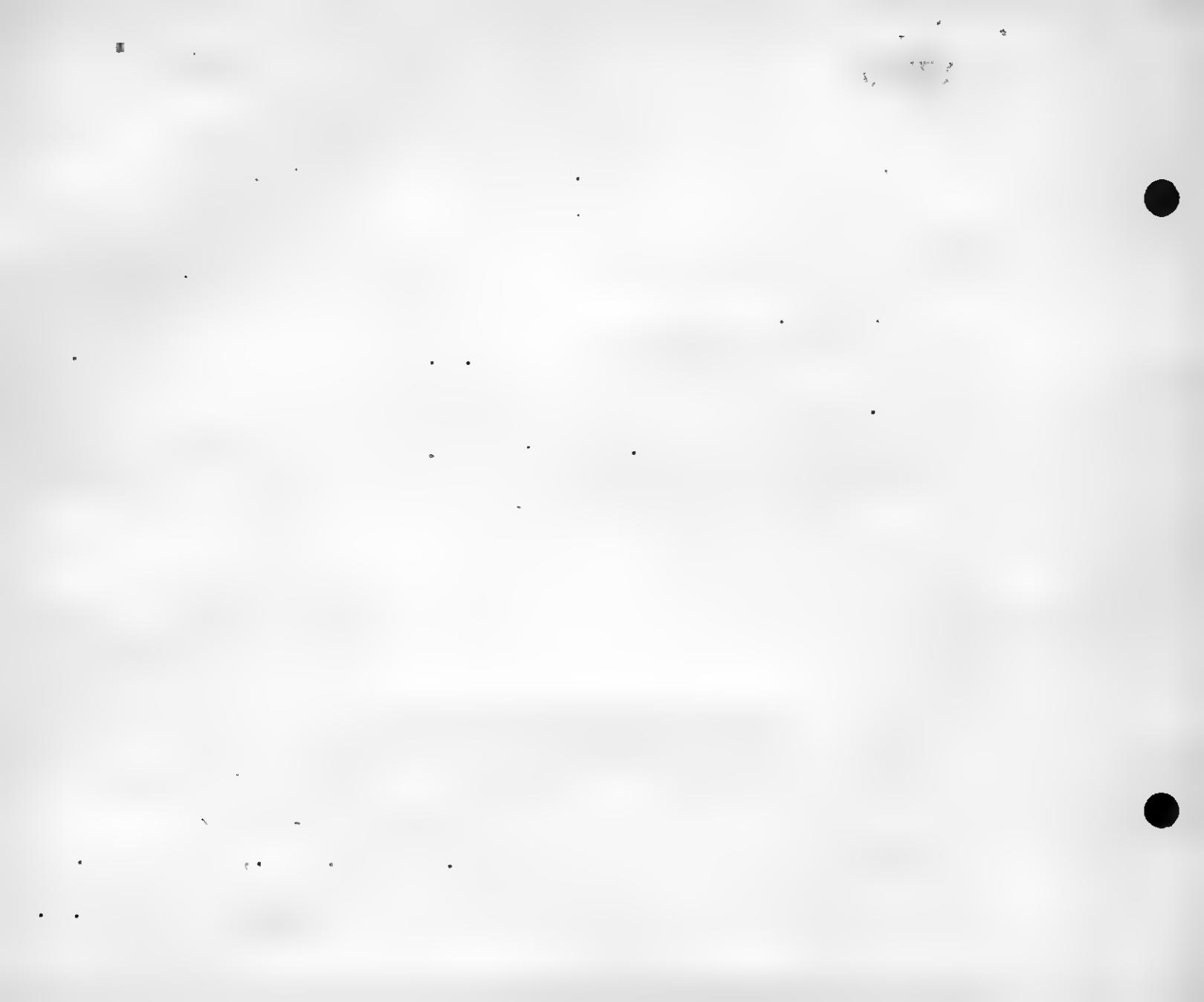
17717

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH d. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 wks. 4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Hts.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>2600 Easton Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <b>Adele</b>	Middle <b>Lizzie</b>	Last <b>Taylor</b>	4. DATE OF DEATH <b>Dec. 24 1966</b>	Month Year
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-1903</b>	9. AGE (In years lost birthday) <b>63 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
13. FATHER'S NAME <b>William A. Gray</b>			14. MOTHER'S MAIDEN NAME <b>Jessie Massey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unk.</b>		17. INFORMANT <b>Nellie G. Foley</b> Address <b>Same as # 2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardio-respiratory arrest</b> DUE TO <b>dissminated cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>uterine cancer.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Westminster</b> (County) <b>S. C.</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-29 1966</b> , to <b>12-24 1966</b> , that (I) (we) last saw the deceased alive on <b>12-19 1966</b> and that death occurred at <b>8:15 PM</b> , from causes and on the date stated above.						22b. DATE SIGNED <b>K. J. Choi</b>
22c. PHYSICIAN'S NAME (Type) <b>Ky Chois'</b>		22d. ADDRESS <b>Pr. Geo. Gen. Hosp., Cheverly, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethel Cemetery</b>		23d. LOCATION (City or Town) <b>Westminster</b> (County) <b>S. C.</b> (State)
24. FUNERAL DIRECTOR <b>3 Larches Lane, Keymills, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John W. Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17721

## CERTIFICATE OF DEATH

17718

**TO HOSPITAL** After death, Page 4 should be signed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

M

## 1. PLACE OF DEATH

## a. COUNTY

Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges County Hospital

3. NAME OF DECEASED  
(Type or print)

First Middle Last

Annie

E. Tegeder

## 5. SEX

Female

## 6. COLOR OR RACE

White

## 7. MARRIED

 NEVER MARRIED  MARRIED DIVORCED  WIDOWED

## 8. DATE OF BIRTH

May 28, 1889

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

Home

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Virginia

## 13. FATHER'S NAME

James L. Floyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  If yes give war record of service

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

## 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e)

422.1 DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   
 } DUE TO (c)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?  YES  NO20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. While at work  Not While at work   
p.m. 19 20d. INJURY OCCURRED While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from ~~Dec. 4, 1966~~ to ~~Jan. 3, 1967~~ that (I) (we) last saw the deceased alive on ~~Dec. 8, 1966~~, and that death occurred at ~~12:47 A.M.~~ from the causes and on the date stated above.

## 22a. SIGNATURE

William Brainin

M.D.

22b. DATE SIGNED  
14/3/67

## 22c. PHYSICIAN'S NAME (Type)

WM BRAININ

ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. 

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF Jan. 4, 1967

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Columbia Gardens

24. FUNERAL DIRECTOR'S SIGNATURE

IVES FUNERAL HOME

2847 Wilson Blvd.

Arlington, Virginia

25a. REC'D BY REGISTRAR JAN 5 1967

25b. REGISTRAR'S SIGNATURE *Judge*



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17722

CERTIFICATE OF DEATH

17719

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges MARYLAND				<b>2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)</b> a. STATE Maryland b. COUNTY Prince Georges																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 16 <b>3 yrs. 2 wks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington College Park</b>		d. STREET ADDRESS <b>4319 Van Buren St.</b>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <b>Josephine</b>		First <b>E.</b>	Middle <b>Thatcher</b>	4. DATE OF DEATH <b>12 20 19 66</b>	Month <b>12</b>	Doy <b>20</b>	Year <b>19 66</b>														
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/21/02</b>	9. AGE (In years lost birthday) <b>64 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>	13. CITIZEN OF WHAT COUNTRY? <b>USA</b>													
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Computer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Last employed at -- Dept. of Army</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>			12. FATHER'S NAME <b>Thomas A. Connors</b>													
13. MOTHER'S MAIDEN NAME <b>Sarah McGinley</b>			14. INFORMANT <b>Decedent</b>			Address			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-20-5369</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confluent bronchopneumonia, bilateral</b>									INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>												
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>lost.</b>									(b) _____												
DUE TO _____									(c) <b>cirrhosis of the liver with liver failure</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arteriosclerosis</b>									19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/6/1963</b> , to <b>12/20/1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/20/1966</b> , and that death occurred at <b>6:45 P.M.</b> , from causes and on the date stated above.									22a. SIGNATURE <b>Moe Weiss</b>			M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/20/66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>									22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>			23a. CEREMONY, REMOVAL (Specify) <b>12/22/66</b>			23b. DATE THEREOF <b>12/22/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>Francis J. Colloring</b>									ADDRESS <b>Collins Funeral Home 3821 14th St NW</b>			25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Collins</b>							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17723

17720

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b>	
3 NAME OF DECEASED (Type or print) <b>First</b> <b>Melvin</b>		d. STREET ADDRESS <b>1105 57th Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4 DATE OF DEATH Month Day Year <b>12 27 19 66</b>	
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Negro</b>	
7. MARRIED WIDOWED <input type="checkbox"/>		NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>8 Oct. 1953</b>		9 AGE (In years lost birthday) <b>13 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Ga</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thompson C. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Louise Thomas (Singleton)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Thompson C. Thomas Chapel Oak, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Status asthmaticus</b> DUE TO <b>Bronchial asthma</b> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
		INTERVAL BETWEEN ONSET AND DEATH hours <b>over 10 yrs</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>12-28-66</b>	
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12/31/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Landover Md.</b>	
24. FUNERAL DIRECTOR <b>R.N. Horton Company</b>		ADDRESS <b>1324 You St. N.W.</b>	
		25a. REC'D BY REG STAR DATE JAN 3 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17724

## CERTIFICATE OF DEATH

17721

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
to FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>			2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			c LENGTH OF STAY IN 1b <b>5 months</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Home</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlotte Hall</b>		
3 NAME OF DECEASED (Type or print) <b>Madeline</b>			First <b>Madeline</b>	Middle <b>Carmel</b>	Last <b>Tippett</b>
4 DATE OF DEATH <b>December 5 1966</b>			Month <b>December</b>	Day <b>5</b>	Year <b>1966</b>
5 SEX <b>Female</b>			6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <b>Aug. 27, 1895</b>			9 AGE (In years last birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Newport, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>William Edward Simpson</b>			14. MOTHER'S MAIDEN NAME <b>Lillian F. Edwards</b>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO <b>578-18-8688</b>	17. INFORMANT Sacred Heart Home, Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>ADENO CARCINOMA OF RECTUM C METASTASES</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT 1 1966</b> to <b>DEC 5 1966</b> that (I) (we) lost saw the deceased alive on <b>DEC 3 1966</b> , and that death occurred <b>at 11 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Thomas F. Collins</b>			22b. DATE SIGNED <b>322-H 21NE.</b>		
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. COLLINS MD</b>			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Check)			23b. DATE THEREOF <b>12/9/66</b>		
23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION (City or Town) (County) (State) <b>Newport Charles Md</b>		
24. FUNERAL DIRECTOR <b>ARCHART FUNERAL HOME INC.</b>			25a. ADDRESS <b>LA PLATA, MD.</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			DATE <b>DEC 12 1966</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**FOR STATE  
HEALTH DEP.**

**17725**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**17722**

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George's</b>	
c LENGTH OF STAY IN 1b <b>45 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5426 85th Avenue, Apt. 201</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Robert Edward Townsend</b>		First <b>Robert</b>	Middle <b>Edward</b>
4. DATE OF DEATH Month <b>12</b>	Month <b>13</b>	Day <b>19</b>	Year <b>66</b>
5 SEX <b>Male</b>	6. CO. OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Land Co</b>	
11 BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John Michael Townsend</b>		14 MOTHER'S MAIDEN NAME <b>Olive Clary</b>	
15 WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/>		16 SOC. SECURITY NO <b>030 18 1026</b>	17 INFORMANT <b>Marie B Townsend</b> Address <b>Lanham, Md.</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration of brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>1/16/7</b> (b) <b>From trauma - auto accident</b> OUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b OF SCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of car involved in a collision</b>	
20c TIME OF INJURY Month, Day, Year Hour am <b>10:50 am 12-13-66</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/> <b>B. St. Rt. 3 300ft north of Rt. 50 Prince George</b>	20e PLACE OF INJURY (Name, farm, factory, street, office bldg etc.) <b>County, 1 d.</b> (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		22. DATE SIGNED <b>12-14-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Dec 16, 1966</b>	23c NAME OF CEMETERY OR COLUMBIARY <b>Arlington National</b>	23d LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>
			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE M  
HEALTH DEPT.

17726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17723

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Doverly</b>		c LENGTH OF STAY IN b <b>2 hrs.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George Hospital</b>		e CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>	
f STREET ADDRESS <b>7420 Marlboro Pike</b>		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Eva</b>		4 DATE OF DEATH (TREMMER) <b>Trumper</b> 12 9 9 66	
5 SEX <b>F</b>		6 COLOR OR RACE <b>W</b>	
7 MARRIED <b>WIDOWED</b>		8 DATE OF BIRTH <b>29 Aug 1898</b>	
9. AGE (In years lost birthday) <b>68 yrs</b>		10. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. COUNTRY OF BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>A.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Emilie Mae Kehoe - MD.</b>		Address <b>1116-1116</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH Minutes	
DUE TO <b>Arteriosclerotic heart disease</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic heart disease</b>		Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>12-1166-</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12/12/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>CEDAR HILL CEMETORY</b>		23d. LOCATION (City or Town) (County) (State) <b>SELTZER 116.</b>	
24. FUNERAL DIRECTOR <b>Hitchcock Bros. &amp; Son, MARLBOROUGH, Md.</b>		25a. REC'D. BY REGISTRAR DATE <b>DEC 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17727

CERTIFICATE OF DEATH

17724

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instl.) or Residence before admission) b. STATE <i>Md</i> COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN Tb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges Hospital</i>		d. STREET ADDRESS <i>22 woodland way</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ALVIN</i>	Middle <i>H.</i>	Last <i>Tucker SR</i>
4. DATE OF DEATH	Month <i>Dec</i>	Year <i>10</i>	Day <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 25-1908</i>
9. AGE (In years last birthday) <i>58</i>	10. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>	11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>maître de l'hôtel Hotel</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Industry</i>	14. MOTHER'S MARRIED NAME <i>Mary sellers</i>	
13. FATHER'S NAME <i>Christian</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Lila A. Tucker Greenbelt Md</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hrs</i>	
<i>+2. 1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <i>Severe A.S.H.D.</i>	64 yrs
		DUE TO (c) <i></i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>p.m.</i> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1956</i> , to <i>12-10-1966</i> , that (I) (we) last saw the deceased alive on <i>12-10-1966</i> , and that death occurred at <i>10-10 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Hans Widak</i>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>12-11-1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>HANS WIDAK M.D.</i>	22d. ADDRESS <i>GREENBELT, MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Speedy) <i>Burial</i>	23b. DATE THEREOF <i>Dec 14, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Colman Manor Prince George's Md</i>
24. FUNERAL DIRECTOR <i>F. Gasch's Sons &amp; Hyattsville Md</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>DEC 16 1966</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
17728 CERTIFICATE OF DEATH 17725															
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)															
a. STATE		Maryland Prince George's													
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Landover													
d. LENGTH OF STAY IN 1b															
Cheverly		9 days													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)															
Prince George's General Hospital															
3. NAME OF DECEASED (Type or print)		First Sarah		Middle E.		Last Turner		4. DATE OF DEATH		Month December	Day 16, Year 66				
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday) 78 yrs.					
Female		White		WIDOWED		DIVORCED		6/15/88		10. UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Washington D.C.				12. CITIZEN OF WHAT COUNTRY U.S.A.			
Retired Lock Smith				Self											
13. FATHER'S NAME John Fitzhugh								14. MOTHER'S MAIDEN NAME Mary Burch							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		6449 Old Landover Road									
no		578 46 8808		Rose M. Athey		Landover, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 10 days															
4:1 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease 2 yrs															
(c) Generalized Arteriosclerosis 2 yrs															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year		Hour a.m. 19		20d. INJURY OCCURRED While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)				
				Not While at work											
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1964, to Dec. 16, 1966, that (I) (we) last saw the deceased alive on Dec 16, 1966, and that death occurred at 2:30 AM from the causes and on the date stated above.															
22a. SIGNATURE Samuel J. N. Sugar															
22c. PHYSICIAN'S NAME (Type)		Dr. Samuel J. N. Sugar		M.D.		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.					
22b. DATE SIGNED Dec 16 1966															
22d. ADDRESS 4637 Eastern Ave., Wash. 18, D.C.															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/19/66		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City, town or county) Colmar Manor P.G.		(State) Md.							
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.															
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE DEC 22 1966		Charles Judge									



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17729

## CERTIFICATE OF DEATH

17726

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RIVERDALE</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bel Air Memorial</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i>	
3. NAME OF DECEASED (Type or print) <i>James L. Frank Vaden</i>		First <i>James</i>	Middle <i>L.</i>
4. DATE OF DEATH <i>Dec. 19 1966</i>		Month <i>Dec.</i>	Day Year <i>19 66</i>
S. SEX <i>m.</i>	5. COLOR OR RACE <i>NEGRO</i>	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH <i>7-2-15</i>	8. AGE (In years last birthday) <i>51 yrs</i>	9. IF UNDER 1 YEAR Months <i>0</i>	10. IF UNDER 24 HRS Days <i>0</i>
10b. KIND OF BUSINESS OR INDUSTRY <i>laborer</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank. Vaden.</i>	14. MOTHER'S MAIDEN NAME <i>Lillie Watson</i>	15. ADDRESS <i>Hospital Record - Bel Air Hospital</i>	
16. SOCIAL SECURITY NO <i>1941-45</i>	17. INFORMANT <i>Hospital Record - Bel Air Hospital</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBROVASCULAR ACCIDENT</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>ARTERIO SCLEROSIS</i> DUE TO lost (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ACUTE PNEUMONITIS</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12-12 1966</i> , to <i>12-19 1966</i> , that (I) (we) last saw the deceased alive on <i>12-19 1966</i> , and that death occurred at <i>9 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>C. J. Holmann</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12-19-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>C. J. Holmann</i>	22d. ADDRESS <i>RIVERDALE MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-24-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln Memorial Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>
24. FUNERAL DIRECTOR <i>John T. Phinco</i>	ADDRESS <i>3015-12 oh 71E</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 23 1966</i>	25b. REGISTRAR'S SIGNATURE <i>John T. Phinco</i>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

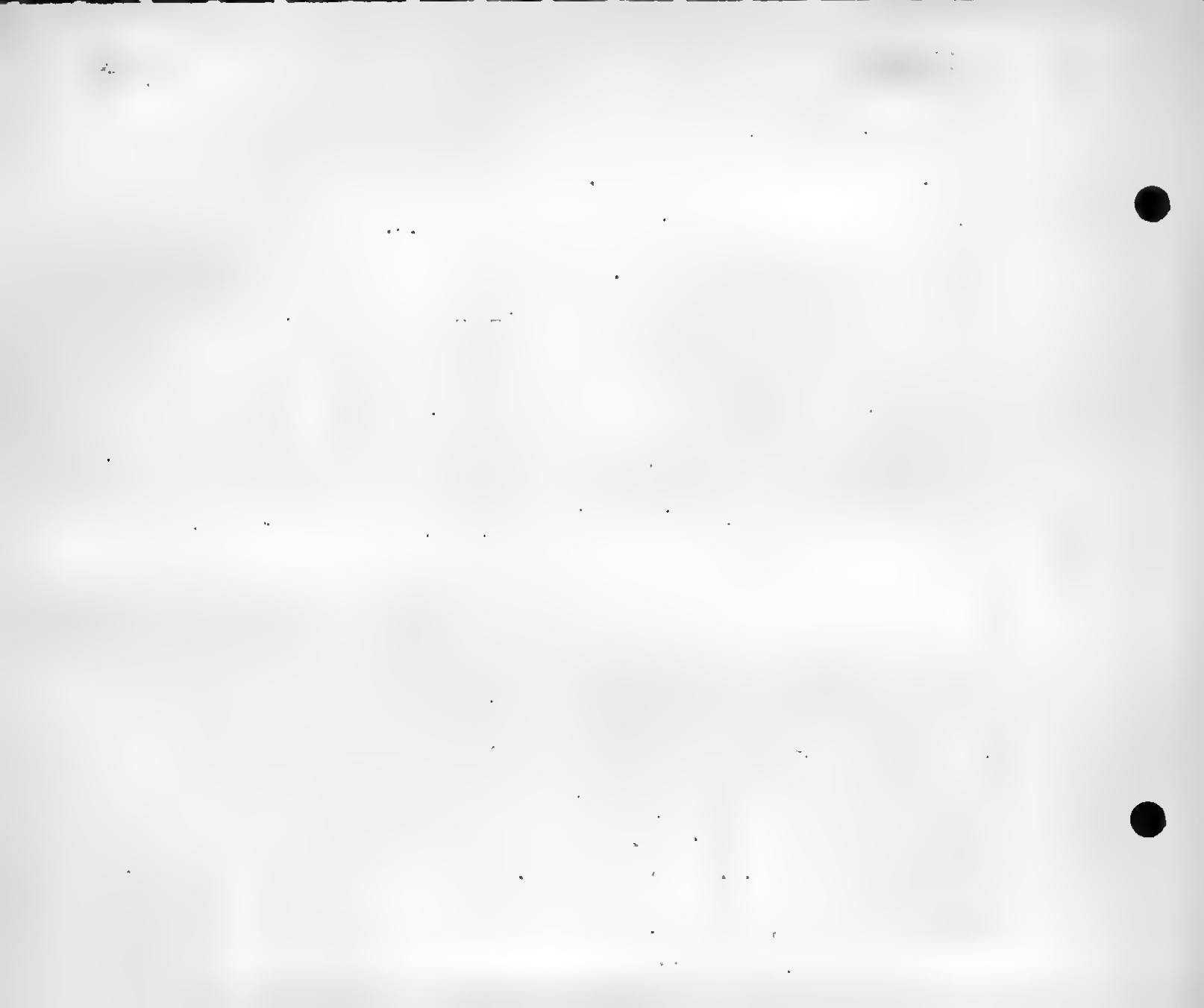
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17730

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17727

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 66 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle N.	Last VanFleet
4. DATE OF DEATH	Month 12	Day 6	Year 19 66
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-16-1906		9. AGE (in years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Arthur Norcross		14. MOTHER'S MAIDEN NAME Annie Backus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 021 03 2161	
17. INFORMANT Robert Van Fleet		Address Warwick Rhode Island.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO Following immobilization of fracture of right femur			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell in living room of home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30 p.m. 12-3-1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) same as #2		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and In my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
		22. DATE SIGNED 12-8-66	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 9, 1966	
23c. NAME OF CEMETERY OR INCINERATOR Arlington National		23d. LOCATION (City, town or county) Arlington Virginia	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR DFC 12 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**17731**

**CERTIFICATE OF DEATH**

**17728**

**1. PLACE OF DEATH**

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN 1b

1 wk.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Hyattsville Nursing Home

6500 Riggs Rd., Hyattsville, Md.

3. NAME OF DECEASED  
(Type or print)

Alice

First

Middle

V

Van Vacter

4. SEX

F

6. COLOR OR RACE

CAU

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

4/20/1885

9. AGE (in years  
last birthday)

81 yrs.

10. IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Bron Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Estate T. D'Andelet

Address  
4011 38th St.  
Brentwood, Md.

INTERVAL BETWEEN  
ONSET AND DEATH

48 hrs.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

442X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

renal disease

Double type bronchopneumonia

Arteriosclerotic cardiovascular

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept., 1966, to 13 Dec., 1966 that (I) (we) last  
saw the deceased alive on 12 Dec. 1966, and that death occurred at at home M, from the causes and on the date stated above.

22d. DATE SIGNED

22a. SIGNATURE

Thomas J. Mattingly

22c. PHYSICIAN'S  
NAME (Type)

Thomas J. Mattingly

22d. ADDRESS

2200 R. St. N.E. Wash. D.C.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

13 Dec. 1966

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

12/16/66

23c. NAME OF CEMETERY OR CREMATORIUM

Centralia Com.

23d. LOCATION (City, town or county) (State)

Centralia, Mo.

24. FUNERAL DIRECTOR

Nalley's Funeral

Home Inc.

25a. ADDRESS

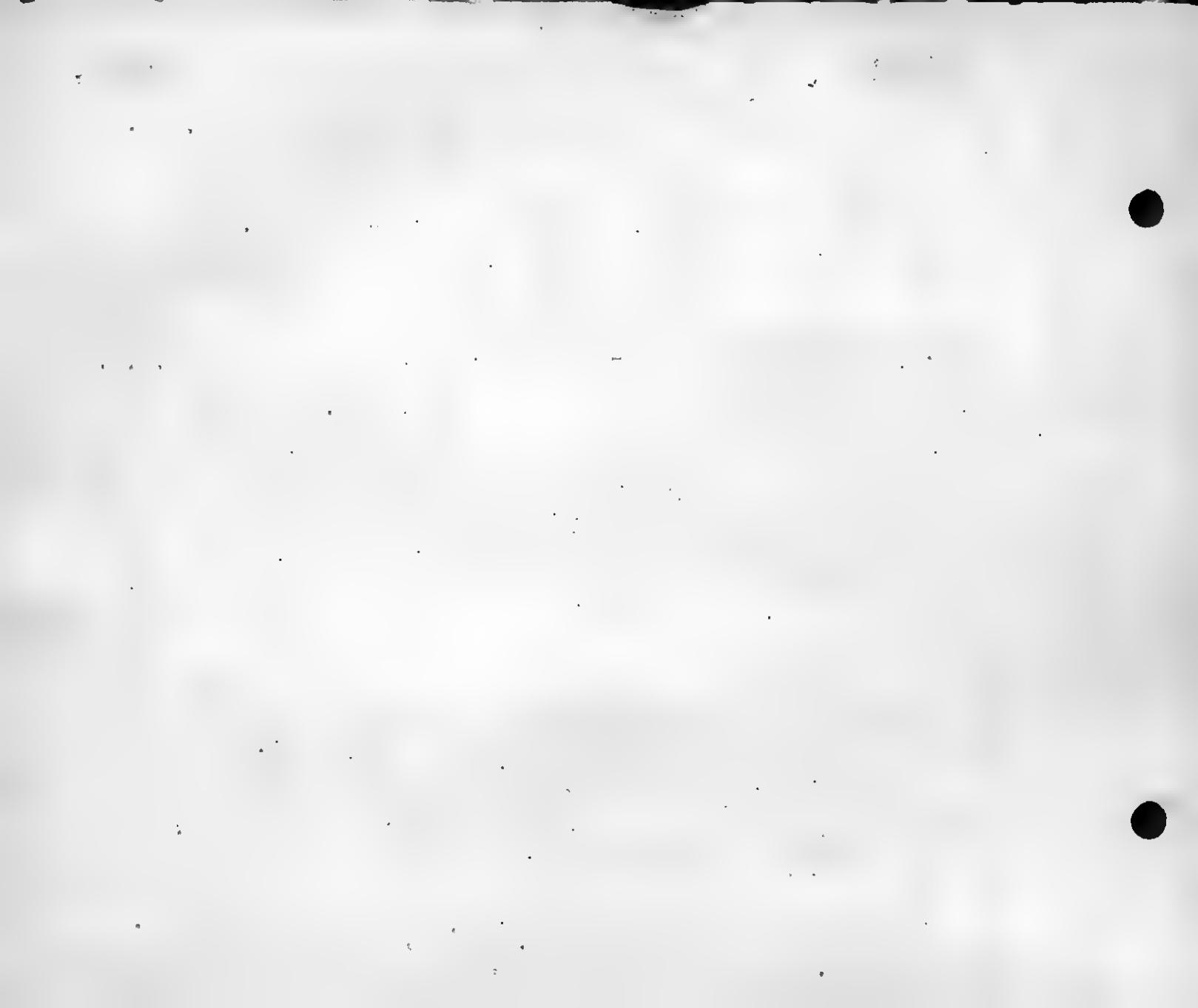
Mt. Rainier

Maryland

25b. REC'D BY REGISTRAR

Charles Judge

25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

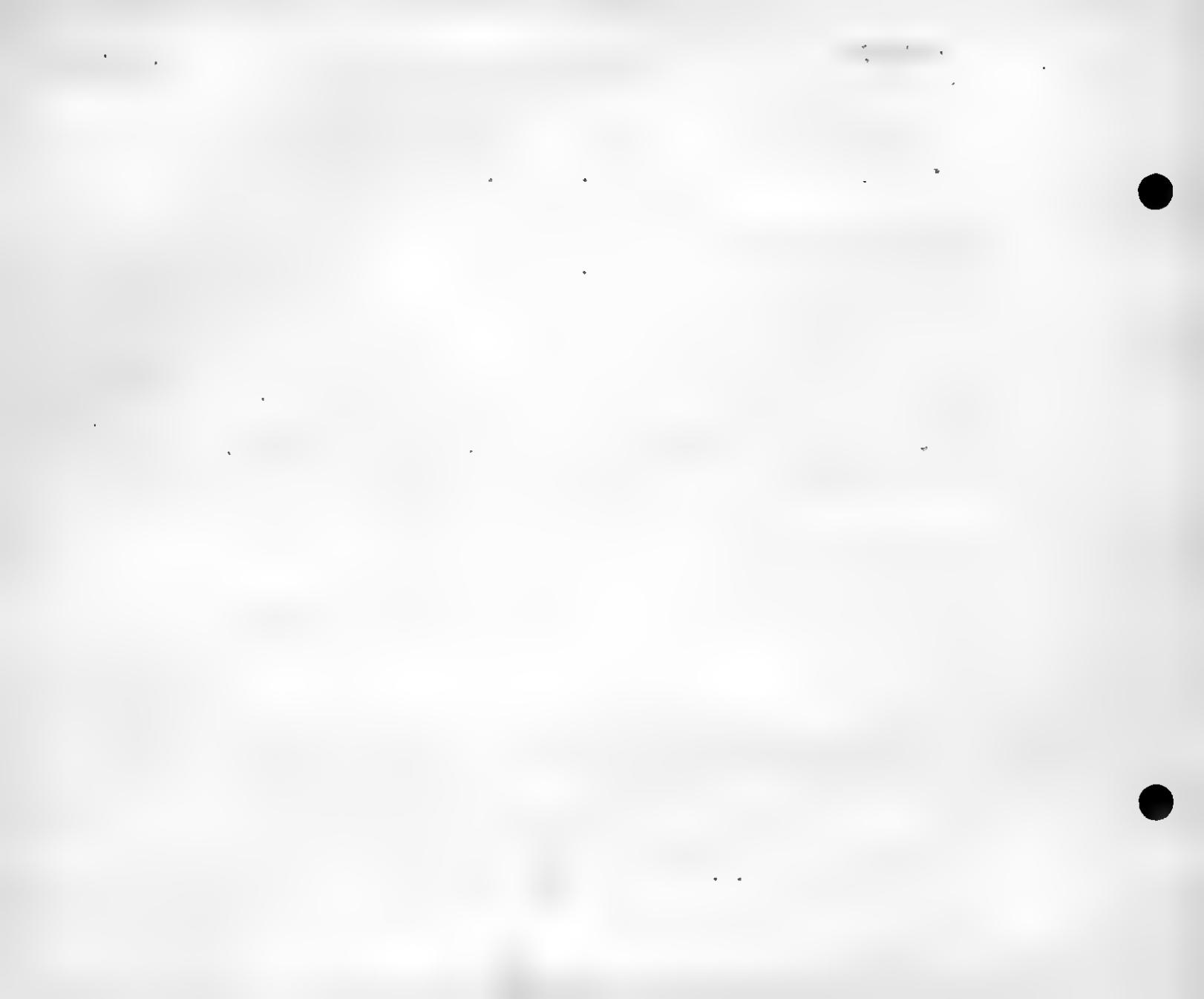
17732

17729

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b. <b>9 hrs. 25 min.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>				
f. STREET ADDRESS <b>7403 Leystone Lane</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) <b>Daniel S. Walker</b>		First <b>Daniel</b>	Middle <b>S.</b>			
4 SEX <b>Male</b>	5. COLOR OR RACE <b>white</b>	6. MARRIED WIDOWED <input type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>1-25-03</b>	9. AGE (In years last birthday) <b>63 yrs</b>	10. DATE OF DEATH <b>12</b>	Month <b>31</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Plumber</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>DANIEL G. WALKER</b>	14. MOTHER'S MAIDEN NAME <b>ELLEN EDELEN</b>	Address <b>111 St. Peters, MD 20784</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) <b>No</b>	16. SOCIAL SECURITY NO <b>225-05-0907</b>	17. INFORMANT <b>Laura Summers - 5524 Rockwood Rd</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro Vascular thrombosis</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>		
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, if item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) <b>Riverdale, Maryland</b>	(State)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John Heft</i>	EXAMINER'S NAME (Type) <b>John Heft, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>1-2-66</b>		
		MD	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <b>111 St. Peters, MD 20784</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1/4/1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Addison Chapel Cemetery</b>	23d. LOCATION (City, Town) <b>Jefferson, Maryland</b>	(County) <b>Montgomery Co., Md.</b>	(State)	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co.</b>	ADDRESS <b>WASHINGTON, DC.</b>	25a. REC'D BY REGISTRAR <b>JAN 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17733

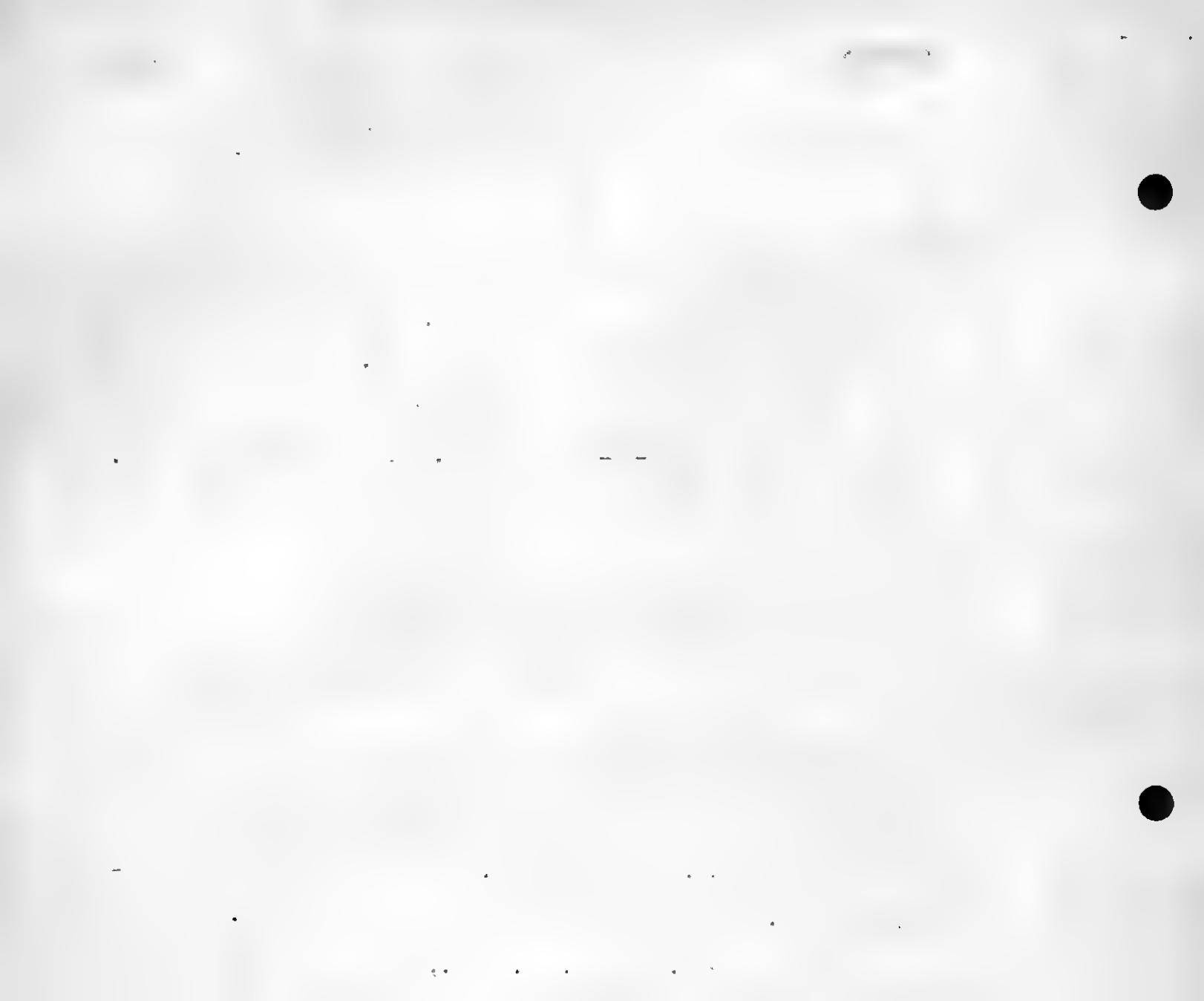
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17730

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

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1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. LENGTH OF STAY IN TB <b>Suitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>4713 Homer Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>Nella Virginia Walker</b>		First <b>Nella</b>	Middle <b>Virginia</b>
3 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a USA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13 FATHER'S NAME <b>William Powell</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>159-22-0081</b>	17 INFORMANT <b>John G. Walker (Son) Same as # 2.</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH MINUTES <b>unknown</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 1B) 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
22. DATE SIGNED <b>12-21-66</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b DATE THEREOF <b>Dec. 21st 66</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>
24 FUNERAL DIRECTOR <i>Simmons Brothers</i>		ADDRESS <b>1661-Gd. Hope Rd. SE, Wash., DC</b>	25a REC'D BY REG STRR <b>DEC 23 1966</b>
			25b REGISTER'S SIGNATURE <i>Charles Judge</i>



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17731

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Haytsville</b>		d. STREET ADDRESS <b>7657 Kilmer Street</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
99										
3. NAME OF DECEASED (Type or print) <b>Mabel Josephine</b>		First	Middle	Last	4. DATE OF DEATH <b>Walter</b>	Month	Day	Year		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1995</b>	9. AGE (In years last birthday) <b>71 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Edwin Costello</b>		14. MOTHER'S MAIDEN NAME <b>Adele Maurice</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Walter Same as # 2</b>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Heart failure</b>						INTERVAL BETWEEN ONSET AND DEATH minutes				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)						20 years				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Riverside</b>		(County) <b>Baltimore</b> (State) <b>Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>1-2-67</b>		
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Prince Geo Md</b>				
24. FUNERAL DIRECTOR <b>Gabriel A. Mattingly</b>		ADDRESS <b>131-1124 1/2 Wash, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
VR A15ME (5) 6M 1/67										



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17735

CERTIFICATE OF DEATH

17732

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If either, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing & Rehabilitation Center		d. STREET ADDRESS 516 Ritchie Road	
e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED First Charles Middle C. Last Watson		4. DATE OF DEATH Month 12 Day 17 Year 1966	
5 SEX Male 6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH 10-3-1884		9 AGE (In years last birthday) yrs 82	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Melvin R. Watson		14. MOTHER'S MAIDEN NAME Agnes E. Moran	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT Effie M. Watson 516 Ritchie Rd Ritchie Md		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Generalized Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mos. Many years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> , 1966 to <u>12-17</u> , 1966, that (I) (we) last saw the deceased alive on <u>12-16</u> , 1966, and that death occurred at <u>12:30</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <i>W.B. Sheer</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <u>12-17-66</u>
22c PHYSICIAN'S NAME (Type) WALTER B. SHEER		22d ADDRESS 6400 MARLBORO PIKE S.E. LERSH, H. 28, DC	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-20-1966	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS Epiphany Cemetery
23d LOCATION (City or town) Forestville		(County) (State) Maryland	
24 FUNERAL DIRECTOR Wilhelm Funeral Home		25a REC'D BY REGISTRAR DATE DEC 21 1966	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>
ADDRESS 4308 Suitland Rd Suitland Maryland			

1



2



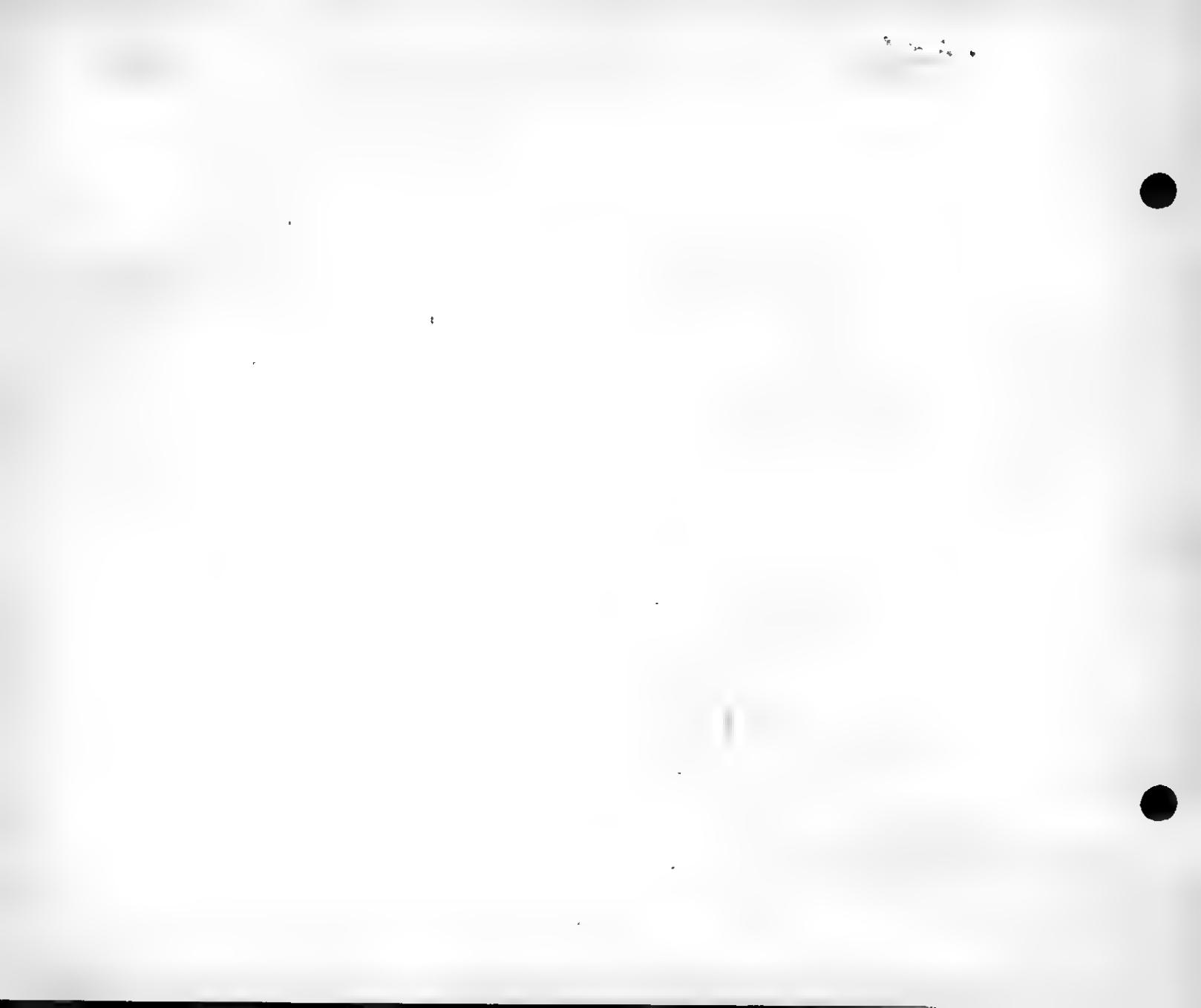
Items 18-21 Film 387 3-27 MARYLAND STATE DEPARTMENT OF HEALTH  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 Item #3 Film #387 L/3/67 pg

FOR STATE  
HEALTH DEPT.

12 *delayed*  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, or any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17733	
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. Prince George b. COUNTY						
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Tuxedo						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS 2310 57th Ave.,						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Wilton	Middle Ellsworth	Last Post	4. DATE OF DEATH	Month 12	Day 9	Year 1966			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> W DOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2 Aug., 1913	9. AGE (in years last birthday) 53 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist			10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) Pro Geo County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wilton Ellsworth Watts Sr		14. MOTHER'S MAIDEN NAME Ethel B Pryor									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) If yes give war or dates of service no			16. SOCIAL SECURITY NO 577 18 0068		17. INFORMANT Annie Helen Watts			Address Tuxedo, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Combined intoxication - alcohol and <i>1880</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) (b) barbiturate DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Took barbiturates while under the influence of alcohol										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF DEATH Month, Day, Year Hour am pm 12-9 19 66		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) Home		20e. (City or town) (County) (State) Tuxedo Pr. Geo. Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED 12-11-66	
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 13, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. RECD BY REGISTRAR DATE DEC 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A1SME GM 1/66											



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Home</b>		e. STREET ADDRESS <b>153 Fairmount Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Lillian Anna Weisbecker</b>		4. DATE OF DEATH Month Day Year <b>December 25 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 7, 1883</b>	
9. AGE (in years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cincinnati, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Benjamin Belmer</b>		14. MOTHER'S MAIDEN NAME <b>Anna Alberts</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Sacred Heart Home, Hyattsville, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Chronic Vascular Gaudent</b> <b>Chronic Cardio Vasculon - nephro</b> <b>Sclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/29/66</b> to <b>12/23/66</b> , that (I) (we) last saw the deceased alive on <b>10/29/66</b> , and that death occurred at <b>10/23/66</b> M, from the causes and on the date stated above.		22b. DATE SIGNED <b>10/29/66</b>	
22a. SIGNATURE <b>Robert C Haile</b>		22b. DATE SIGNED <b>10/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT C HAILE</b>		22d. ADDRESS <b>35 NEW YORK AVE N.W. WASH, DC.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-29-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>MT CLIVET CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BLADENSBURG RD WASH, DC.</b>	
24. FUNERAL DIRECTOR <b>WW Chambers Co</b>		25a. REC'D BY REGISTRAR <b>W. C. W. 10/29/66</b>	
		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17738

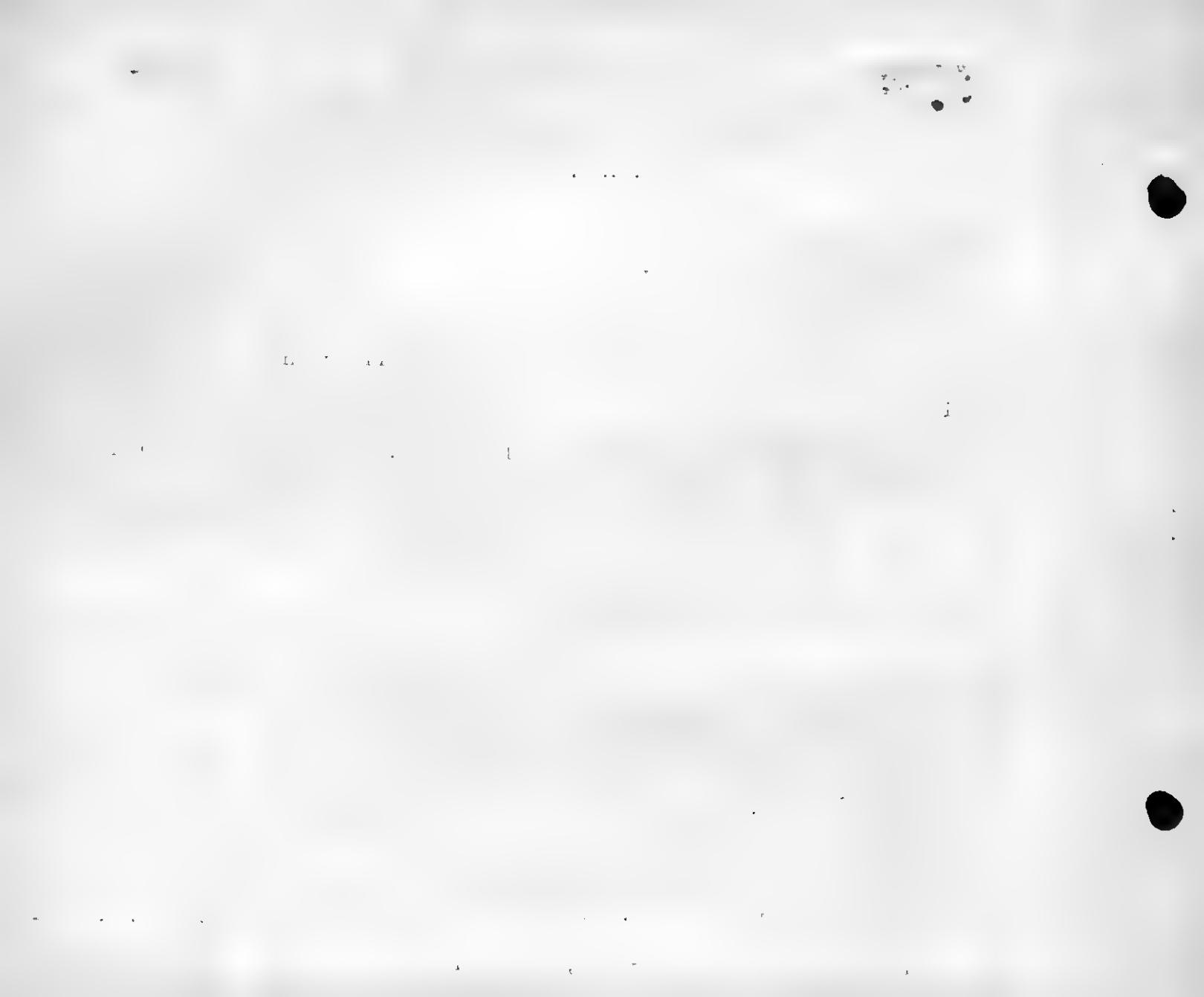
## CERTIFICATE OF DEATH

17735

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb D. O. A.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital			d. STREET ADDRESS 9332 4th street				
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED First William V. Wert Middle			4. DATE OF DEATH Month Day Year December 6, 1966				
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1898				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired optical shop			10b KIND OF BUSINESS OR INDUSTRY Navy Yard				
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Wert			14. MOTHER'S MAIDEN NAME Aura Maury				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <input type="checkbox"/> no		16. SOCIAL SECURITY NO 207 07 2197		17. INFORMANT Florence T. Wert Same as #2 (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute coronary occlusion</i> DUE TO <i>arterial occlusion due to fib</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <i>9 mo.</i>			INTERVAL BETWEEN SONSET AND DEATH <i>sunset</i>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)		
21 I certify that (I) (this hospital) attended the deceased from <i>May 19 66</i> , 1966, to <i>Dec 6</i> , 1966, that (I) (we) last saw the deceased alive on <i>Nov 2</i> , 1966, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <i>LW Malin</i>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/10/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>LW Malin MD.</i>		22d. ADDRESS <i>Kensdale, Md.</i>					
23a. BURIAL, CREMATION, Cremation		23b. DATE THEREOF 12/10/66	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln crematory		23d. LOCATION (City or Town) Colmar Manor	(County) P.G.	(State) Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland			ADDRESS		25a. REC'D BY REGISTRAR DEC 8 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66							



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT. VI

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17736

1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
a. COUNTY Prince George MARYLAND		a. STATE Md. b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Rt. 1, Box 51 (Brady's Lane)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First: Angela Middle: Rose Last: Wesley		4. DATE OF DEATH Month: 12 Day: 11 Year: 1966	
S SEX F	6 COLOR OR RACE W	7 MARRIED W DIVORCED	8 DATE OF BIRTH 24 Sept., 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael J. Wesley, Sr.		14. MOTHER'S MARRIED NAME Patricia G. Sardo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) If yes give dates of service		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Michael J. Wesley, Jr. Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral pneumonitis			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) _____			
DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 12-11-66			
23a. BURIAL, CREMATION, BURIAL & CREMATION 12/15/66		23b. DATE THEREOF 12/15/66	
23c. NAME OF CEMETERY OR Crematory Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md.		ADDRESS 25a. REC'D BY REGISTRAR DEC 19 1966 DATE	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17740

## CERTIFICATE OF DEATH

17737

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1. PLACE OF DEATH

a. COUNTY

Prince George

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Laurel

c. LENGTH OF STAY IN lb

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

620 8th St.

3. NAME OF DECEASED  
(Type or print)First  
Matilda

Middle

Last  
Ann Wesley

4. SEX

F

6. COLOR OR RACE

Negro

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

Jan. 14 1877

4. DATE  
OF  
DEATH

Dec.

Month

Day

Year

a. IS RESIDENCE  
ON A FARM?YES  NO 

10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

13. FATHER'S NAME

Washington Carter

14. MOTHER'S MAIDEN NAME

Sarah Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Evan Wesley (S.)

Address

Maple Tree  
Laurel, Md.INTERVAL BETWEEN  
ONSET AND DEATH

10 yrs

20 yrs

20 yrs

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

A-S-C-V-A Disease

Heart A-S-

Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Hour a.m.  
p.m.Month, Day, Year  
White  
at work   
Not White  
at work 20d. INJURY OCCURRED  
20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2/15/66 to 12/7/66, that (I) (we) last saw the deceased alive on 12/7/66, and that death occurred at 12:00 M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)MD ATTENDING  
PHYS.   
22d. ADDRESSMED. DIRECTOR   
STAFF PHYS. 22b. DATE  
SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE OF REMOVAL

12/12/66

23d. LOCATION (City, town or county)

(State)

Muirkirk

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Robert L. Snowden Rockville, Md.

ADDRESS

25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE

DEC 15 1986 Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17741

## CERTIFICATE OF DEATH

Reg. Dist. No.

17738

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover, Md.</b>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Magnolia Gardens Nursing Home</b>	
d. STREET ADDRESS <b>1225 13th St NW</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nash. Washington</b>	
3. NAME OF DECEASED (Type or pri.) <b>Flora</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>March 13, 1879</b>	
9. AGE (In years last birthday) yrs <b>87</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>8</b> Days <b>27</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Wilbur Wetzel</b>		14. MOTHER'S MAIDEN NAME <b>Flora H. Hessick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>GEO. L MASON (Bro.)</b>		Address <b>Landover, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>1966</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic cancer of lung, breast</b> DUE TO (c) <b>cancer of breast</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1966</b> , 19 <b>66</b> to <b>12/10/66</b> , 19 <b>66</b> , that I last saw the deceased alive on <b>12/9/66</b> , 19 <b>66</b> , and that death occurred at <b>10:35 AM</b> , from the causes and on the date, stated above			
ACTUAL SIGNATURE <b>Leon Levitsky</b> ADDRESS (Street, city or town, state) <b>3408-R.I. Ave., Mt. Rainier, MD</b> DATE SIGNED <b>12/10/66</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 13/66</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>WASHINGTON NATIONAL CEM.</b>		22d. LOCATION (City, town, or county) <b>SNITLAND, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M.W. HYSON CO., INC.</b>		24a. REC'D. BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>1300-N ST. N.W. WASH. D.C.</b>		24b. REGISTRAR'S SIGNATURE	



FOR STATE  
HEALTH DEPT.

17742

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

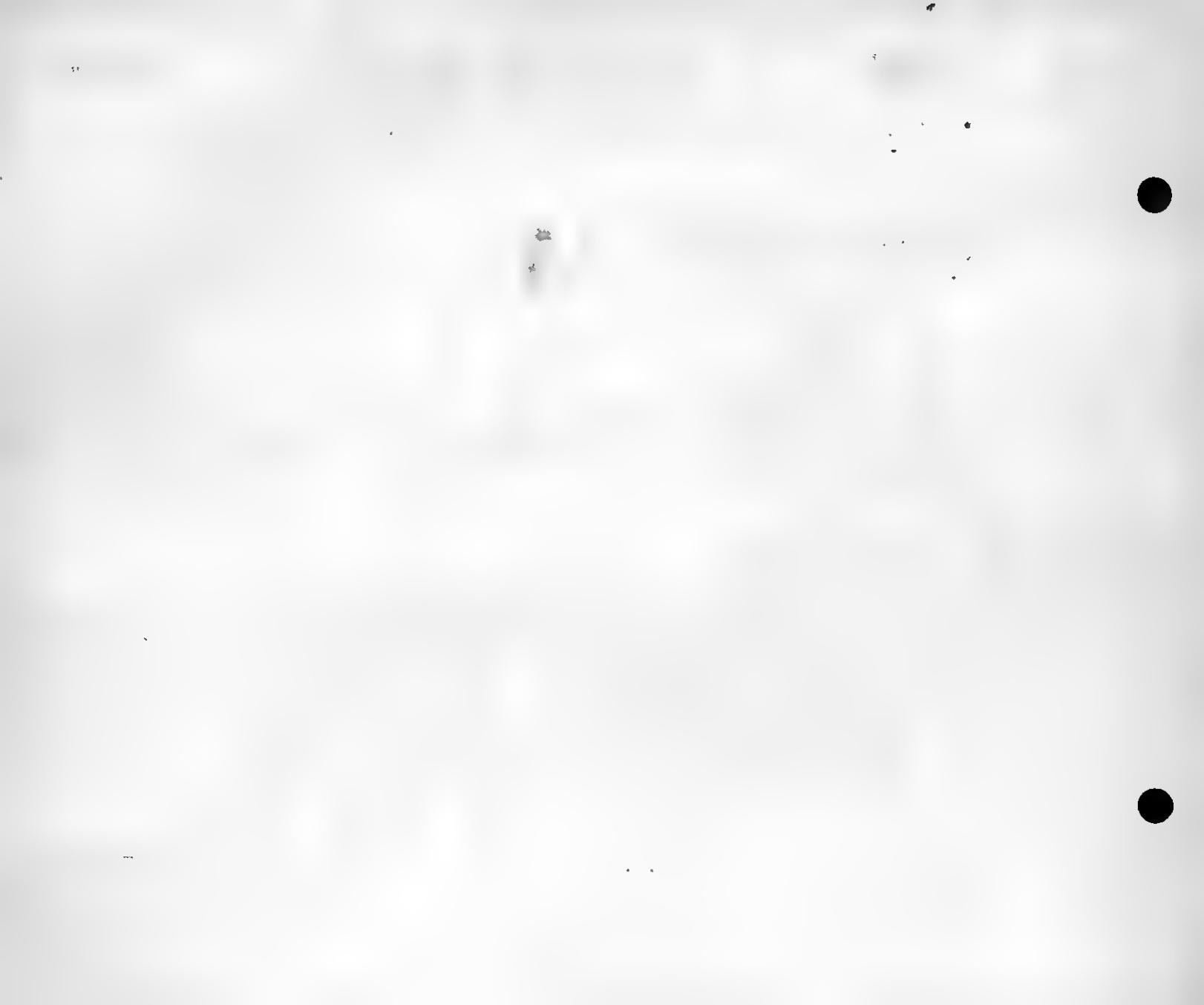
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17739

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institut on Residence before adm ission on) b. STATE Md. b. COUNTY Prince George		
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		c. LENGTH OF STAY IN lb Landover		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home-Same as #2		d. STREET ADDRESS 2607 Prince George Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Drucie Middle Marie Last Jetstone		4. DATE OF DEATH 12-17 Month 19 Year 66		
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Pierre McMahon		14. MOTHER'S MAIDEN NAME Laura Walden		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		
17. INFORMANT Richard Walden 248 West Vine St., Charleston, Illinois		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
		(b) Arteriosclerotic heart disease DUE TO (c)		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street offce bldg etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Keloe, M.D., Riverdale
22. DATE SIGNED 12-18-66		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County)		
23a. BURIAL, CREMATION, REMOVALS <sup>Spreading</sup> Burial		23b. DATE THEREOF Dec 23, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park	23d. LOCATION (City or Town) (County) (State) Frostburg Maryland
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		ADDRESS	25a. REC'D. BY REGISTRAR DEC 27 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part in item 11. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items 1, 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1410,									



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17744

CERTIFICATE OF DEATH

17741

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Prince Georges</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN lb <b>12 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e STREET ADDRESS <b>3557 55th Ave. Apt. 11</b>	
3 NAME OF DECEASED (Type or print) <b>Baby</b>		First <b>Boy</b>	Middle <b>Williams</b>
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8 DATE OF BIRTH <b>14 Dec. 1966</b>		9 AGE (In years last birthday) yrs <b>12</b>	
10a LSUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) <b>-</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Dwight C. Williams Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Haronitorre</b>	
15 WAS DECLARED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17 INFORMANT <b>Mr. Dwight C. Williams Jr. (above addressed)</b>		Address <b>(Father) address</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fetal mortality</b> DUE TO <b>7/16 X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>{</b> DUE TO (c) <b>}</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>30 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <i>James G. Nalley</i>		22b. DATE SIGNED <b>22a. ADDRESS</b>	
22c PHYSICIAN'S NAME (Type)			
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12/28/66</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat. Cem.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>	23d LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>
		23e REC'D BY REGISTRAR <b>DEC 20 1966</b>	23f REGISTRAR'S SIGNATURE <b>Charles Judge</b>



1  
FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17745 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17742

1. PLACE OF DEATH B. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) B. STATE	
Prince George MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Prince George	
Clinton		Clinton	
c LENGTH OF STAY IN MD		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
10A.		Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Southern Md. Medical Center		7500 Grace Drive	
e. IS RESIDENCE ON A FARM?		e. IS RESIDENCE ON A FARM?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	David	Edward	Wilson
4. DATE OF DEATH	Month	Day	Year
12	8	19	66
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	27 June 1938	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
STEAM FITTER	WORK. CORP	12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	U.S.	
JOSEPH D. WILSON	JANETTE PERCIVAL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address SAME AS DECEASED <input checked="" type="checkbox"/>
No	577-52-8474	MRS BARBARA WILSON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)			
Laceration of brain			
803.4			
DUE TO			
(b) Multiple skull fractures			
DUE TO			
(c) Trauma - auto accident			
INTERVAL BETWEEN ONSET AND DEATH			
Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 13-9-66			
MEDICAL CERTIFICATION		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> BT CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		Driver of car which ran off road and hit pole.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:15 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Old Branch Ave., nr. Woodley Rd. P.G. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, A.D., Riverdale	
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL Burial 13 Dec 1966 Washington National Cemetery Suitland, Maryland			
23d. LOCATION (City, town or county), (State) 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE W.W. Chambers Co. Riverdale, Md. DATE DEC 5 1966 Charles Judge			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with a 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17746

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17743

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Ritchie 1005 Ritchie Road, S.E.</b>	
3. NAME OF DECEASED (First) <b>John</b> Middle <b>Everett</b> Last <b>Windsor</b>		4. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>1966</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Dec. 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>	
13. FATHER'S NAME <b>John Albert Windsor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Violet Garner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Clara Estelle Windsor-#2.</b>	
17. INFORMANT <b>Same as Item 16</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO _____ (c) _____	
		INTERVAL BETWEEN ONSET AND DEATH minutes <b>over 5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>12-30-66</b>	
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, I.D. Riverdale, Md.</b>	
23a. BURIAL/CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/3/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Pr. Geo Md.</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		25a. REC'D BY REG STRAR DATE <b>JAN 6 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17247

## CERTIFICATE OF DEATH

17744

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN b <b>1 day</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>		
f. STREET ADDRESS <b>9505 Sheridan St.</b>			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Joseph C. Wolfe</b>			First <b>Joseph</b>	Middle <b>C.</b>	Last <b>Wolfe</b>
4. DATE OF DEATH Month <b>December</b>	Month <b>30.</b>	Day <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/13/26</b>	9. AGE (In years last birthday) <b>40 yrs</b>
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Joseph C. Wolfe Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Stella Fagan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) If Yes, give dates of service <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>579 26 3232</b>		17. INFORMANT Address <b>Mary E. Wolfe Same as #2 (wife)</b>	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Severe Malnutrition &amp; emaciation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>151 X</i> (b) <i>Carcinoma of stomach with complete obstruction</i> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Arlington</b>	(County) (State) <b>Arlington Va.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1963</b> , to <b>Dec. 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 30, 1966</b> , and that death occurred at <b>4:10 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Frederick E. Musser</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/30/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Frederick E. Musser, M.D.</b>		22d. ADDRESS <b>4410 74th Ave., Bellemere, Md.</b>			
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE THEREOF <b>1/3/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Arlington Va.</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>F. Gaschis Son - Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 3 1967</b>	25b. REGISTRAR'S SIGNATURE <i>W. Wesley Judd</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17748

## **CERTIFICATE OF DEATH**

MARYLAND  
17745

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove Carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17748					CERTIFICATE OF DEATH						
Item 3, 17-17-1m 684 1/17/62 ph					17745						
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)						
PRINCE GEORGE'S MARYLAND					a. STATE b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE GEORGE'S COUNTY						
c. LENGTH OF STAY IN lb											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last					4. DATE OF DEATH Month Day Year						
GEORGE M. W. Wood					12 26 1966						
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 93 yrs.			
M		W		11-8-73		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			
1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY		Farm		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Wood					14. MOTHER'S MAIDEN NAME Malinda Schnoover						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
no		219 54 7241		Mrs. Teenefeather Daughter Same as #2		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2-3 moed			
33 x		DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral thrombosis		(b)		Cerebral arteriosclerosis			
DUE TO cause (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from _____, 1966, to 12-26, 1966, that (I) (we) last saw the deceased alive on 12-26-66 19, and that death occurred at 10:54 AM, from the causes and on the date stated above.											
22a. SIGNATURE Donald C. Edson					22b. DATE SIGNED 12-26-66						
22c. PHYSICIAN'S NAME (Type) Donald C. Edson					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Hyattsville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/66		23c. NAME OF CEMETERY OR CREMATORIUM Riverside		23d. LOCATION (City, town or county) Towanda		(State) Pa			
24. FUNERAL DIRECTOR E. Gasch's Sons		ADDRESS Hyattsville, Md.		25. REC'D BY REGISTRAR DEC 2 J 1966		25b. REGISTRAR'S SIGNATURE F. Gasch, Judge		DATE			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17749

## CERTIFICATE OF DEATH

17746

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN Tb <b>57 days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d STREET ADDRESS <b>6500 D St.</b>	
3. NAME OF DECEASED (Type or print) <b>Grace</b>		First <b>J.</b>	Middle <b>Wood</b>
4. DATE OF DEATH <b>December 29</b>	Month <b>1966</b>	Day <b>Year</b>	Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6/3/03</b>		9. AGE (In years last birthday) yrs. <b>63</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Esengbrietsen</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Pauline</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles E. Wood</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>475A</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Pneumonia</b>		DUE TO (b) <b>Massive Pulmonary Embolism</b> DUE TO (c) <b>Pneumonia</b>	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Charles E. Wood</b>
20f. (City or town) <b>Suitland</b>		(County) <b>Prince George</b>	
(State) <b>MD</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>7/16</b> , 1965, to <b>12-24</b> , 1966, that (I) (we) last saw the deceased alive on <b>12-29</b> , 1966, and that death occurred at <b>2:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles E. Wood</b>		22b. DATE SIGNED <b>12-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR DAVID ANDERS</b>		22d. ADDRESS <b>3308 Dodge Park Rd, Landover Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>
24. FUNERAL DIRECTOR <b>Matthew G. J. S. E. D.E.</b>		ADDRESS <b>131-1176 S.E. D.E.</b>	
25a. REC'D BY REGISTRAR <b>Jan 3</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Wood</b>	
DATE JAN 3 1967		Signature	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17750

## CERTIFICATE OF DEATH

17747

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>M.D.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANHAM, Md.</b>		b. COUNTY <b>PRINCE GEORGES</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Heights, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MAGNOLIA GARDEN'S NURSING HOME</b>		d. STREET ADDRESS <b>6801 PINEWAY</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ETHEI</b>	Middle <b>C.</b>	Last <b>WOODWARD</b>
S SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>SEPT. 15, 1887</b>
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housenurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>washington D.C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert W. Chappel</b>		14. MOTHER'S MAIDEN NAME <b>Era Bedell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> ) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>219 34 9961</b>	
17. INFORMANT <b>Thompson E Woodward</b>		Address <b>Woodlawn Apt 202 Mt. Rainier, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>cerebral arteriosclerosis</b> DUE TO (c) <b>cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 10, 1966</b> , to <b>Dec. 15, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec. 11, 1966</b> , and that death occurred at <b>11:55 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Don B Cameron</b>		ATTENDING PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12-15-66</b>
22c. PHYSICIAN'S NAME (Type) <b>Don B. Cameron 3503 Perry St.</b>		22d. ADDRESS <b>417 RAINIER, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 19, 1966</b>	
23c. NAME OF CEMETERY OR BURIAL GROUND <b>St. John's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bethesda, Prince George's, Md.</b>	
24. FUNERAL DIRECTOR <b>J. Beachs son, Hyattsville, Md.</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>James J. Magee</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6 Film #G380 5/18/67 pc

## CERTIFICATE OF DEATH

17748

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17751

1. PLACE OF DEATH  
a. COUNTY

PRINCE GEORGE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

3 hours

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

PRINCE GEORGE GENERAL

3. NAME OF  
DECEASED  
(Type or print)

First Middle

Q

Young

4. SEX  
Female

6. COLOR OR RACE

Charity

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

5. DATE  
OF  
DEATH

Box 1052

Month

Last

Year

e. IS RESIDENCE  
ON A FARM?  
YES  NO 

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PRINCIPAL PUBLIC SCHOOL, MD. STATE

8. DATE OF BIRTH

6-6-09

9. AGE (In years last birthday) 57 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

13. FATHER'S NAME

WILLIAM D. QUANDER

11. BIRTHPLACE (County &amp; State, or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

213-03-2109

17. INFORMANT Address BENJ. M. YOUNG SEE 2 B

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

33IX

DUE TO

Conditions, if any, which gave

rise to immediate cause (a),

stating the underlying cause

lost.

(b)

DUE TO

(c)

DUE TO

Hypertension crisis

Fever and hypertension

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o.m.  
p.m. 1920d. INJURY OCCURRED  
While  Not While   
at work  at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 12/20, 1966, to 12/31, 1966 that (I) (we) last saw the deceased alive on 12/31, 1966 and that death occurred at 12 A.M. from causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)M.D. ATTENDING  
PHYS. MED.  
DIRECTOR  STAFF  
PHYS. 

22b. DATE SIGNED

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
BURIAL

24. FUNERAL DIRECTOR

23b. DATE THEREOF

1/7/67

23c. NAME OF CEMETERY OR CREMATORIAL

MT. OLIVET CEMETERY

23d. LOCATION (City or Town)

WASHINGTON

(County)

D.C. (State)

1820 ADDRESS

9TH ST. N.W.

1820 ADDRESS

9TH ST. N.W.

25b. RECD BY REGISTRAR

JAN 5 1967

25b. REGISTRAR'S SIGNATURE

DATE

JAN 5 1967

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17752

CERTIFICATE OF DEATH

17749

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 66 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 318 Second Street		d. STREET ADDRESS 318 Second Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED First MIDDLE Lost		4. DATE OF DEATH Month Doy Year	
DECEASED (Type or print) AGNES VIRGINIA ZALONIS		December 8, 1966	
S. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1895
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done prior to taking life, even if retired) Clerk-Stenogr; USGovt		10b. KIND OF BUSINESS OR INDUSTRY USGovt; DepAgric	
11. BIRTHPLACE (County & State, or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Collins		14. MOTHER'S MAIDEN NAME John Anna White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-56-1498 Husband: John Anthony Zalonis	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Hypo-albuminemia, hypo-kalemia, anemia 2865 DUE TO (b) cirrhosis of liver Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (c) subnutrition, adult-type (dietary selectivity) DUE TO life-long		INTERVAL BETWEEN ONSET AND DEATH 6 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (July to Cholelithiasis; Enterocolitis due to Staph. aureus Oct 66)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 Sept 1966, to 8 Dec 1966, that (I) (we) last saw the deceased alive on 7 Dec 1966, and that death occurred at 6 A.M., from causes and on the date stated above.		22b. DATE SIGNED 8 December 1966	
22a. SIGNATURE J. Richard Compton, M.D.		22d. ADDRESS 612 Main Street, Laurel, Md.	
22c. PHYSICIAN'S NAME (Type) J. Richard Compton, M.D.		23d. LOCATION (City or Town) (County) (State) Laurel Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St Marys Cem.		23d. LOCATION (City or Town) (County) (State) Laurel Md.	
24. FUNERAL DIRECTOR De Witt Lannigan, Laurel, Md.		25a. REC'D BY REGISTRAR DATE DEC 21 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

